



Dear Doctor,

Please complete the required fields below, as this information must accompany any pathology request for **TRANSLUCENCY SCREENING**.

The completed form can be sent in with the sample and our couriers, or alternatively can be **FAXED** to (02) 8745-6599.

FIRST TRIMESTER SCREENING INFORMATION (11-13 weeks) – RPAH

For interpretation of results, the following information is required by the testing laboratory:

Patient Name		D.O.B	
Requesting Doctor Name		Address:	

PAPPA / FBHCG

Clinical Details	
Date of Collection	
LMP	
Maternal age at EDD	
Gestation at date of sample	
Weight	
Insulin dependant diabetes	Yes / no
Any previous history	
Smoker	Yes / no

SECOND TRIMESTER SCREENING (DOWNS) (After 14 weeks) – RPAH

AFP / HCG / UE3

Same information as above



PLEASE NOTE: Weight at the time of sample collection is an important DOWNS risk factor.

The risk results depend on the accuracy of information provided by the referring doctor.

Risk calculations are statistical and have no diagnostic value