All India Institute of Medical Sciences, Jodhpur
Department of Biochemistry
PRE-NATAL SCREENING REQUISITION FORM

*SCREENING TYPE	☐ FIRST TRIMESTER 10W+0D – 13W+6D (DUAL MARKER)		☐ SECOND TRIMESTER 15W+0D – 22W+6D (QUADRUPLE MARKER)	
Referring Physician:				
Sample collection date:				
PATIENT DETAILS:				
FULL NAME:			PATIENT ID:	
ADDRESS :			CONTACT NUMBER:	
*DOB:	*WEIGHT: KG	HT CM	RACE :	
PREGNANCY DETAILS:				
*PARA (Live Birth)		*GRAVIDA		
*LMP (DD/MM/YY) *EDD (Calculated) *EDD (USG)		*No.of.fetus	Singleton/twins/triple/multiple	
Insulin dependent DM	Yes/no/unknown	Blood RH type: positive/negative/unknown		
Down syndrome history	Yes/no/unknown	OSB (Open Spina Bipida) history: Yes/no/unknown		
Conception	Natural/Assisted	Smoker: Yes/no/unknown		
Autoimmune disorder: Yes/No If Yes: ……			K/C/O:	
Assisted conception : induced IUI/ IVF/ICSI/OTHER			Drug H/O : SSRI/CBZ/valproate/other	
Date of IVF:	Date of embryo transfer:	Egg donor DOB:	Egg donor age:	
*ULTRASOUND DETAILS:				
SCAN DATE:			CRL: mm	
NT: mm			BPD: mm	
DVPI:			HC: mm	
FL: mm			NASAL BONE: PRESENT/ABSENT	

*Compulsory/Must details

*Signature
(*Name, Designation, Contact No.)