Maternal Screen
Patient Information

Piedmont ATHENS REGIONAL

Patient Name _____ _____

Hospital Account Number_____

Required Information		LIS Code
Maternal date of birth (DOB)-not age mm/dd/yyyy	_____/_____/_____	7MDOB
Weight of patient-enter up to one decimal only		7MW
Patient's Due Date mm/dd/yyyy	_____/_____/_____	7DUE
Estimated Due Date determined by: circle one	**ULTRASOUND / LMP**	7DET
Date of last menstrual period mm/dd/yyyy	_____/_____/_____	7DLMP
Repeat specimen-circle one	**Y** or **N**	7RPSP
Multiple pregnancy-circle one	1 2 3	7TWIN
Previous Aneuploidy-circle one	**Y** or **N**	7PRAN
Maternal race-circle one	**W** (white) **B** (black) **A** (Asian) **O** (Other)	7RACE
Insulin dependent diabetic-circle one	**Y** or **N**	7DIAB
Family history of neural tube defect-circle one	**Y** or **N**	7FMHS
Doctor's name/phone number		7DOC