

Patient Information Sheet

Down's Syndrome Screen in Pregnancy



Essential Clinical Information required:

Patient's full name:	
Date of birth of patient:	/ /
Date of last menstrual period:	/ /
Weight:	
Calculated weeks gestation at date of collection:	
ULTRASOUND:	Yes / No
IF YES:	
Date of Ultrasound:	/ /
No. of weeks gestation at date of ultrasound:	
No. of foetuses:	
Insulin dependent diabetes mellitus:	Yes / No
Previous pregnancies with:	
Neural Tube Defect:	Yes / No
Down's Syndrome:	Yes / No
If previous Down's Syndrome pregnancy:	
Non inherited:	Yes / No
Inherited translocation:	Yes / No
Unknown:	Yes / No

Doctor's Signature _____

- **The above information is necessary for interpretation of results.**
- **Because of the complexity and importance of this information, the practice requests this to be provided in writing by the referring doctor.**

For your nearest Lavery Collection Centre, please phone

Tel 02 9005 7000

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