

Quad Screen Patient Info

Patient _____ DOS ___/___/___

Pt DOB ___/___/___ Mat'l Wt. _____lbs. Race: _____

Insulin Dependence? YES NO

History of Downs? YES NO

History of Neur. Tube? YES NO

1st Screen YES NO

Number of fetuses _____

Please provide at least one of the following:

- 1) Date of LMP: ___/___/___
- 2) Gestational Age by U. S.: _____wks _____days
- 3) Date of U.S.: ___/___/___
- 4) Est. date of delivery: ___/___/___
- 5) Current gestational age: _____wks _____ days