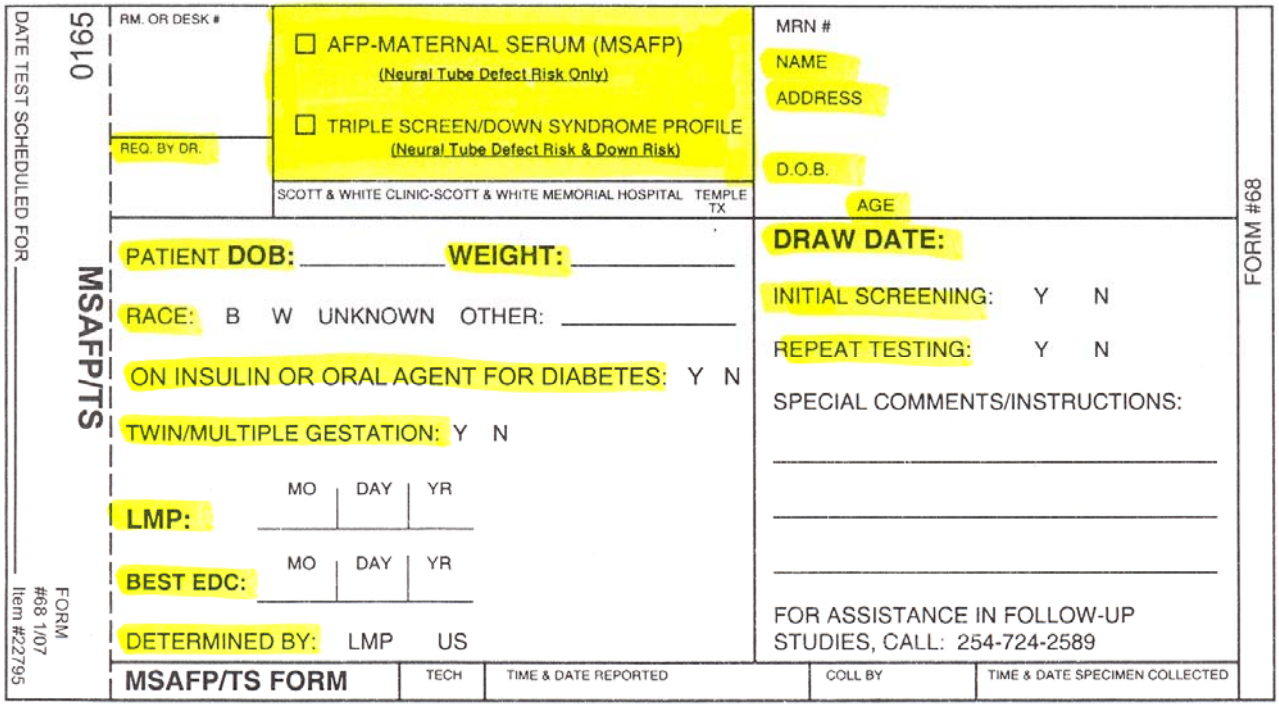
AFP / DSP



DATE TEST SCHEDULED FOR _____

0165

MSAFP/TS

FORM #68 1/07 Item #22795

RM. OR DESK #

REQ. BY DR.

☐ AFP-MATERNAL SERUM (MSAFP)
(Neural Tube Defect Risk Only)

☐ TRIPLE SCREEN/DOWN SYNDROME PROFILE
(Neural Tube Defect Risk & Down Risk)

SCOTT & WHITE CLINIC-SCOTT & WHITE MEMORIAL HOSPITAL TEMPLE TX

MRN #

NAME

ADDRESS

D.O.B.

AGE

FORM #68

PATIENT **DOB:** _____ **WEIGHT:** _____

RACE: B W UNKNOWN OTHER: _____

ON INSULIN OR ORAL AGENT FOR DIABETES: Y N

TWIN/MULTIPLE GESTATION: Y N

LMP: MO | DAY | YR _____

BEST EDC: MO | DAY | YR _____

DETERMINED BY: LMP US

DRAW DATE:

INITIAL SCREENING: Y N

REPEAT TESTING: Y N

SPECIAL COMMENTS/INSTRUCTIONS:

FOR ASSISTANCE IN FOLLOW-UP STUDIES, CALL: 254-724-2589

MSAFP/TS FORM | TECH | TIME & DATE REPORTED | COLL BY | TIME & DATE SPECIMEN COLLECTED