

Date : day / mth / yr

**PATIENT INFORMATION :**

Patient Name : \_\_\_\_\_ Date of Birth : day / mth / yr  
 IC : \_\_\_\_\_ Age / Gender : \_\_\_\_\_ / \_\_\_\_\_ Clinic/Hospital Ref. No : \_\_\_\_\_  
 Race : Malay / Chinese / Indian / Others \_\_\_\_\_ Smoker : Yes / No

**PRENATAL SCREENING :**

- First Trimester Screening
- Second Trimester Screening/Triple test
- Antenatal \_\_\_\_\_
- Others \_\_\_\_\_

**PRENATAL DIAGNOSTIC:**

- Rapid Aneuploidy Test (ChromosomesCheck)
- Karyotype
- Others \_\_\_\_\_

**Specimen :** Blood / AF / CVS / Cord Blood/ POC/  
 Others \_\_\_\_\_

**SPECIMEN AND CLINICAL DETAILS:**

Maternal : Weight \_\_\_\_\_ kg Height : \_\_\_\_\_ cm  
 Blood collection date : day / mth / yr  
 LMP : day / mth / yr EDD : day / mth / yr GA \_\_\_\_\_ wks  
 No Foetus : Singleton/Twins  
 CRL: \_\_\_\_\_ mm GA ( \_\_\_\_\_ wks \_\_\_\_\_ days)  
 NT : \_\_\_\_\_ mm  
 Nasal bone : Present / Absent

**FOR ASSISTED REPRODUCTION ONLY:**

Method : \_\_\_\_\_  
 Transfer : day / mth / yr Extraction : day / mth / yr  
 Donor birth date : day / mth / yr

**REFERRING DOCTOR'S NAME, ADD, TEL AND FAX :**

**CLINICAL DIAGNOSIS/REASON FOR TEST REQUEST :**  
 (Family/previous history, foetal loss, Abnormal screening test/scan)

Doctor's copy