Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Cell-Free DNA Prenatal Screen Patient Information

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date *(mm-dd-yyyy)*	Sex ☐ Male ☐ Female
Referring Provider Name *(Last, First)*	Phone	Fax*
Genetic Counselor Name *(Last, First)*	Phone	Fax*

**Fax number given must be from a fax machine that complies with applicable HIPAA regulations.*

Clinical Information

Gestational Age

Weeks: _____ Days: _____ Expected delivery date *(mm-dd-yyyy)*: _____

Method Used to Determine Gestational Age

☐ Last menstrual period ☐ Ultrasound ☐ Other: _____

Maternal Height: _____ ☐ inches / ☐ cm (Check unit of measure used.)

Maternal Weight: _____ ☐ lbs / ☐ kg (Check unit of measure used.)

Reason for Testing (Check all that apply.):

- ☐ Low-risk pregnancy
- ☐ Advanced maternal age
- ☐ Abnormal first or second trimester screening test
- ☐ History of previous pregnancy with trisomy. Specify chromosome: _____
- ☐ Parental balanced translocation with increased risk of fetal trisomy 13 or trisomy 21
- ☐ Ultrasound anomalies/fetal malformation
- ☐ Pregnancy conceived with donor egg/donor embryo/gestational carrier. Specify: _____
- ☐ Other, specify: _____

Number of Fetuses Present

☐ Singleton ☐ Twins ☐ Triplets ☐ Other: _____

Print