



Laboratory Number

Questionnaire Risk Screening for Down Syndrome and Neural Tube Defects

Patient details:

Surname	Given names
Date of birth	Current weight (Required for accurate results)
/ /	kgs

First Trimester Down Syndrome Screening with ultrasound for Nuchal Translucency (NT)
 You should be between 8 weeks and 13 weeks 6 days of gestation. (If PIGF requested, can collect from 9 weeks)

Date of NT ultrasound (if known): / /

Second Trimester Down Syndrome and Neural Tube Defect Screening
 You should be between 15 weeks and 20 weeks of gestation.

Please complete only ONE of the following options to give the best estimate of weeks and days pregnant:

Date of last ultrasound: / /

 weeks and days. Number of fetuses:

(Estimate of weeks and days pregnant on day of ultrasound) (Single = 1; Twins = 2)

or

Expected date of delivery (EDD): / /

or

Last normal menstrual period (LNMP): / /

or

Clinical examination: weeks on: / /

(Date of examination)

Please answer 'Yes' or 'No' to the following questions:

Have you had a previous pregnancy with a Neural tube defect?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a previous Down Syndrome pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have insulin-dependent diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you undergone amniocentesis in the past month?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your pregnancy the result of an IVF procedure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you a smoker?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered 'Yes' to any of the questions above, please give further details:

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