

TEST REQUISITION FORM:

1. **General:**

Sample From:.....
.....

Patient's Name.....
Age.....Sex:.....
E - mail.....Tel.....
Referring Doctor's Name:.....
E-mail.....Tel.....

Sample Description
Serum in Plain Blood, EDTA, Citrate, Flouride / Heparin
Plasma(EDTA / Citrate / Flouride / Heparin)
Body Fluid Source.....
Urine (Spot / 24 hrs.) Volume.....ml.
Tissue: From in Formalin / Saline / Others

INVESTIGATIONS REQUIRED

- 1.....
- 2.....
- 3.....
- 4.....
- 5.....
- 6.....
- 7.....
- 8.....

Following History is Compulsory for Triple Marker Test

Birth Date:Weight.....Kg.LMP.....Twin: Y/N

Insulin Dependent Diabetes: Y/N
IVF/IUI Date:.....

(Please attach Ultra Sound Copy)

Clinical History :

Drug Therapy:

Last Dose...../...../.....at.....Hours

2. **Histopathology/ Cytology/Bone Marrow:**

DR. B. LAL CLINICAL LABORATORY

Performa for Histopathology/Cytology/Bone marrow

Registration number/Center name-

Date-

Patient Name-

Age-

Sex-

Specimen-

Site-

Authorized Signatory

3. Triple Test:

Patient's Name _____ Referred By _____
Husband's Name _____ Date _____
Phone _____
Patient's Weight _____ K g s Lbs
Patient's date of birth ___/___/___ Collection Date ___/___/___
LMP Date ___/___/___
Initial Sample _____ Repeat test _____ Reported date ___/___/___
Present Pregnancy : _____ Single _____ Twins

Previous History of Down's Syndrome

Previous History of Neural Tube Defect (NTD)

Insulin dependent diabetes

Bleeding or spotting in the last two weeks

IVF, ovarian stimulation, other.....

History of Previous Pregnancies :

Ultrasound Details:

Date of ultrasound : ___/___/___ CRL measurement : _____ mm
(minimum : 45 mm, maximum : 84 mm)
Nuchal Translucency thickness* : ___ . ___ mm BPD measurement : _____ mm
(minimum : 26 mm, maximum : 52 mm)
Average Gestational Age on the day of USG ___ weeks ___ days