Laboratoire
CERBA

CUSTOMER ACCOUNT NUMBER:

LABORATORY/HOSPITAL NAME:

SAMPLE REQUEST FORM
DOWN'S SYNDROME SCREENING

(AFP, FREE HCG, UNCONJUGATED ESTRADIOL)

SAMPLE REQUIREMENTS

- 1 ml serum, shipped at room temperature
- Sample must be collected between the 15th and 20th week of amenorrhea

PATIENT DETAILS

Name

Firstname

Birth date (D D M M Y Y Y Y)

Last menstrual period date (D D M M Y Y Y Y)

Start of pregnancy date (D D M M Y Y Y Y)

Number of foetuses

Patient's weight (in Kg)

History of previous Down's Syndrome pregancy — No ☐ Yes ☐

Other important clinical information: _____

_____

_____

SAMPLE DETAILS

Sample collected on (D D M M Y Y Y Y)

Doctor's/Nurse's signature:

Laboratory/Hospital stamp