MATERNAL SERUM SCREENING TEST

Down syndrome, Neural Tube Defects and other Pregnancy Pathologies

SA PATHOLOGY

Patient Details

Ethnic Group: ☐ Caucasian ☐ Aboriginal ☐ Asian ☐ African-Caribbean

Family Name		Given Name(s)	
Date of Birth	UR Number	Medicare Number	
Address			
Suburb		State	Postcode

Clinical Details – Mandatory

☐ **First Trimester Screen** ☐ **Second Trimester** ☐ **Neural Tube Defect only** ☐ **Omega-3 status (SAHMRI)**

EDD/LMP _____ Cycle length (days) _____ Maternal weight (Kgs) _____

GA Clinical weeks + days _____ on _____

GA Ultrasound weeks + days _____ on _____

Crown-rump length (CRL) mm _____ on _____

Pregnancy: ☐ Singleton ☐ Twins ☐ Triplets **IVF:** ☐ Yes ☐ No Age at egg retrieval/age of egg donor _____

Pregnancy complications: Diabetes *(IDMM only)* ☐ Yes ☐ No Smoker ☐ Yes ☐ No **Previous** ☐ T21 ☐ T18/13

Name of Imaging Practice: _____

For first trimester screening risk assessment an Ultrasound request form is required for Nuchal Translucency, 11-14w0d.

Patient status at the time of the service or when the specimen was collected:

- ☐ a private patient in a private hospital or approved day hospital facility
- ☐ a private patient in a recognised hospital
- ☐ a public patient in a recognised hospital
- ☐ an outpatient public of a recognised hospital
- ☐ an outpatient private of a recognised hospital

Privacy Disclosure SAMSAS requires the personal information contained in this request form for the purpose of Risk assessment and Program Audits. SAMSAS may therefore request copies of ultrasound and cytogenetic reports from your doctor in order to complete its testing and audits.

Medicare Benefits (Section 20A of the Health Insurance Act 1973). I offer to assign my right to the approved pathology practitioner who will render the requested pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner.

☐ Do Not send to My Health Record

✗ _____ Date ___/___/___

Patient signature

Practitioner's Use Only

_____

(Reason patient cannot sign)

5-10ml CLOTTED BLOOD SAMPLE Gel or plain tube - no anticoagulant

First trimester blood sample 9-14w0d Second trimester blood sample 14w1d-20w6d

I have verified FULL NAME, DOB and URN on the sample label and request form verbally with the patient and/or checking the patient's ID band.

Collector's Signature _____ Specimen Collected / / : Hrs

Requesting Doctor

☐ **SAMSAS risk assessment calculation not required**

Name:

Provider No:

Address:

Tel: Fax:

Email:

Signature:

Request Date:

Copy of report to:

Name:

Address:

Deliver to: South Australian Maternal Serum Antenatal Screening (SAMSAS) Program
SA Pathology, Specimen Reception Area, Level 3, Royal Adelaide Hospital. Port Rd ADELAIDE SA 5000.
T (08) 8161 7285 F (08) 8161 8085 samsas.program@health.sa.gov.au www.wch.sa.gov.au/samsas.html

Reset Form

Save As

Where to have your blood taken (other than by your doctor)

SA	SA Pathology Patient Centres Visit www.sapathology.sa.gov.au for your nearest Patient Centre	8222 3000 (Metropolitan) 1800 188 077 (Regional)
TAS	Hobart Pathology	6223 1955
	North West Pathology	6430 6762
	Launceston Pathology	6334 3636
	Royal Hobart Hospital (Specialist Clinic)	6222 8644
	Pathology South	6166 0150
	Launceston General Hospital	6348 7690
NT	Darwin Pathology	8922 8076

Privacy Note: The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of government health programs, and may be used to update enrolment records. Its collection is authorised by provisions of the Health Insurance Act 1973. The information may be disclosed to the Department of Health and Ageing or to a person in the medical practice associated with this claim, or as authorised/required by law.