ST. THOMAS CLINICAL REFERENCE LABORATORY

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Patients Instructions

Please find enclosed the instructions you need to perform the tests your doctor ordered.
Following instructions allow tests can be performed satisfactorily.

Alpha Feto Protein

1. Laboratory Name: _____
2. ____Plus ____Tetra ____Maternal
3. Patient Name: _____
4. Date simple collected: _____
5. Birth Date: _____
6. Years: _____
7. Weight: _____
8. Height: _____
9. Date of last menstrual period: _____
10. Date of chilbirth: _____ (___)Sonogram (___) Menstruation
11. Gestation Weeks: _____
12. Date of last sonogram: _____
13. Weeks Gestation to date sonogram: _____
14. Diabetic Patient: ____ Yes ____No ____Insulin Dependent
15. Have you had previous abortions: ____Yes ____No
16. Type of pregnancy: ____Single ____Twins ____Multiple (more than 2)
17. Family history:

    ___ Neural tube defects ___Patient ___Couple ___ Previous child

    ___ Down syndrome

    ___ Chromosome abnormalities
18. Complications of pregnancy:

    ___ Irregular menstrual periods

    ___ Vaginal bleeding

    ___Others

    NOTE ALL FIELDS ARE REQUIRED.