EXACT

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DOWN'S SYNDROME RISK ASSESSMENT

姓名
Name:.. 中文名：...

性別
Gender:.............. 年齡
Age:............ 出生日期
D.O.B.:......................... 身分證/護照號碼
H.K. I.D. no.: ....(.....)
/ Passport no.

Race: ☐ White ☐ Black ☐ Chinese / Other: ....

Insulin dependent diabetes : ☐ No ☐ Yes

Multiple of Pregnancy : ☐ Singleton ☐ Twins

Maternal body weight : ....(kg / lbs)

day month year

Sample drawn on : ..../.............../..................

Last Menstrual Period (LMP): ..../.............../..................

Gestational date (by U/S) : ..../.............../..................

Gestational age (by U/S) : ....(weeks)...............(days)

AFP : ....ng/ml

hCG : ....IU/ml

Note: Sample must be taken AFTER 15 weeks and BEFORE 20 weeks of pregnancy (16 - 18 weeks is ideal).
Please attach this form to the request form.