

LAB No.

<b>SURNAME</b>	<b>FIRST NAME</b>	<b>NHI No.</b>
<b>D.O.B.</b>	<b>AGE</b>	
Gestational Age – By Dates	– By Scan	Previous Amniocentesis?
Obstetric History	G	P
Test(s) Requested (please tick box)	Karyotype <input type="checkbox"/> ;	AFP <input type="checkbox"/> ;
		Aneuscreen <input type="checkbox"/> ;
By (signature)	Other <input type="checkbox"/> (please state)	
Reason (attach details if applicable)		
<b>DO PARENTS WISH TO KNOW SEX?</b>		
Dr / Midwife supervising pregnancy?	Drs Phone No. (for results)	
Address		
Additional copies to	Address	
Procedure performed by	At	
Specimen type	Date	
Volume of specimen	Appearance	
<b>LAB USE ONLY</b>	Culture date	
Test code(s)		
Arrival time / date	Referral form checked by	

