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

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

Clinical Details – Mandatory

F First Trimester Screen F Second Trimester F Neural Tube Defect only F 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: F Singleton F Twins F Triplets IVF: F Yes F No Age at egg retrieval/age of egg donor_____

Pregnancy complications: Diabetes (IDMM only) F Yes F No Smoker F Yes F No Previous F T21 F 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:

F a private patient in a private hospital or approved day hospital facility
F a private patient in a recognised hospital
F a public patient in a recognised hospital
F an outpatient public of a recognised hospital
F 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 Bene ts (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.

F 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 veri ed 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 F SAMSAS risk assessment calculation not required

Name:	Copy of report to:
Provider No:	Name:
Address:	Address:
Tel: Fax:	
Email:	
Signature:	
Request Date: / /	

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