



COMMENTS

SIGNATURE/TITLE

PRINT NAME

Patient's name, address and home phone # must appear above.

LABORATORY

REFERRING PHYSICIAN:

INITIAL LABS	DATE/INITIALS	RESULT	DATE/INITIALS	COMMENTS / ADDITIONAL LAB	
Hct / Hgb		_____ % _____ GM/dl			
BLOOD TYPE		A B AB O			
Rh					
ANTIBODY SCREEN					
RUBELLA					
RPR					
HBs Ag					
HIV					
HEMOGLOBIN ELECTROPHORESIS		AA AS SS AC SC AF			
URINE CULTURE/SCREEN					
PAP SMEAR					
CHLAMYDIA					
GC					
ULTRASOUND					
MSAFP					
AMNIO / C.V.S.		<input type="checkbox"/> Refused <input type="checkbox"/> Accepted <input type="checkbox"/> Not Offered			
KAROTYPE					
ALPHA-FETOPROTEIN					
P.P.D./TINE					
24-28 Week Labs (When Indicated)	DATE/INITIALS	RESULT			
DIABETES		1 hr _____			
GTT (IF SCREEN ABNORMAL)		___ FBS ___ 1hr ___ 2hr ___ 3hr			
Rh ANTIBODY SCREEN					
RhIG GIVEN (28 WEEKS)		Signature _____			
	DATE/INITIALS	RESULT			
ULTRASOUND					
VDRL					
GC					
Hct/Hgb		_____ % _____ GM/dl			
CHLAMYDIA					
INIT.	Signature/Title	Print Name	INIT.	Signature/Title	Print Name