California Department of Public Health
Genetic Disease Screening Program
Telephone: 510/412-1502

NUCHAL TRANSLUCENCY EXAM DATA

CALIFORNIA PRENATAL SCREENING PROGRAM

NT PRACTITIONERS: PLEASE WRITE CLEARLY. USE CAPITAL LETTERS. THIS FORM CAN ALSO BE DOWNLOADED FROM THE GDSP WEBSITE AT http://www.cdph.ca.gov/programs/PNS/Pages/default.aspx UNDER THE NT PRACTIONER INFORMATION HEADING. IT MAY BE FILLED IN ELECTRONICALLY AND PRINTED.

CLINICIANS: PLEASE WRITE THIS INFORMATION ON THE 1ST OR 2ND TRIMESTER LAB FORM FOR SUBMITTAL TO THE CALIFORNIA PRENATAL SCREENING PROGRAM WITH THE BLOOD SPECIMEN.

PATIENT INFORMATION

LAST NAME *

FIRST NAME *

BIRTHDATE * MM-DD-YY

NUCHAL TRANSLUCENCY INFORMATION (if NT done)

NT PRACTITIONER CRED # *

NT SUPERVISOR CRED #

NT SITE CODE

NT EXAM DATE * MM-DD-YY

CRL (FETUS A) *

NT (FETUS A) *

TWIN PREGNANCY? * YES NO

IF TWINS, WHAT IS THE CHORIONICITY?

MONOCHORIONIC

DICHORIONIC

UNABLE TO DETERMINE

CRL (FETUS B) *

CHECK BOX IF UNABLE TO MEASURE CRL

NT (FETUS B) *

CHECK BOX IF UNABLE TO MEASURE NT

*REQUIRED FIELDS

If the CRL is less than 45 mm or greater than 84 mm, the NT exam data cannot be used for risk assessment. Convert the CRL or BPD to gestational age, and include this on the ultrasound report that you are providing the clinician.

If you have already entered NT data into SIS, it is not necessary to send this form to the clinician.