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

Print Form

NUCHAL TRANSLUCENCY EXAM DATA

CALIFORNIA PRENATAL SCREENING PROGRAM

NT PRACTITIONERS: PLEASE WRITE CLEARLY. THIS FORM CAN ALSO BE DOWNLOADED FROM THE GDSP WEBSITE AT http://www.cdph.ca.gov/programs/PNS/Pages/ntpractitioner.aspx UNDER THE PROGRAM INFORMATION HEADING.

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.

FORM COMPLETED BY

NAME *(Last, First)*

TELEPHONE NUMBER

PATIENT INFORMATION

NAME * *(Last, First)*

TEST REQUEST FORM # *(If Available)*

DATE OF BIRTH *

NAME OF PRENATAL CARE PROVIDER

NUCHAL TRANSLUCENCY INFORMATION (if NT done)

NT PRACTITIONER CRED # *

NT SUPERVISOR CRED #

NT SITE CODE

NT EXAM DATE * - -

CRL (FETUS A) * . mm

NT (FETUS A) * . mm

TWIN PREGNANCY? * YES NO

IF TWINS, WHAT IS THE CHORIONICITY?

MONOCHORIONIC

DICHORIONIC

UNABLE TO DETERMINE

CRL (FETUS B) * . mm

NT (FETUS B) * . mm

CHECK BOX IF UNABLE TO MEASURE CRL

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. If CRL is greater than 84 mm convert the CRL or BPD to gestational age, and include this on the ultrasound report that you are providing the clinician.**
- **CRL and NT must be reported in millimeters. Please round to one decimal place.**
- **If you have already entered NT data into SIS, it is not necessary to send this form to the clinician.**

FIELDS WITH ASTERISKS * ARE REQUIRED. WITHOUT THIS INFORMATION, NT WILL NOT BE USED FOR RISK ASSESSMENT.