TheMKWay

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Patient Name
MRN No
Date of Birth

1st Trimester- Fetal anomaly screening Consent form

PART A (Please complete this form and bring it with you to your scan appointment)

1) Have you read/understood the information about the screening test for you and your baby? **YES/NO**

2) Have you had a previous pregnancy affected by Down's syndrome (Trisomy 21), Edwards' syndrome (T18) or Patau's syndrome (T13)? **YES/NO**

3) Have you received fertility treatment during this pregnancy? **YES/NO**

(If yes, please provide the following information; if no, proceed to Question 4)

Please select and complete the following: (if applicable)

In Vitro Fertilisation (IVF): Egg extraction date .....

Transfer date .....

Ovulation induction therapy: **YES/NO**

Donor egg: Age of donor .....

Egg extraction date .....

Transfer date .....

Please be aware that a result cannot be determined without this information

4) **Smoking Status** Do you smoke? **YES/NO**

(If yes, please provide the following information; if no, proceed to Question 5)

How many cigarettes do you smoke per day? .....

Please circle the following (if applicable):

a) Nicotine replacement therapy (NRT): Vaping Patches E-cigarettes Other

b) Stopped in pregnancy **YES/NO**

Please continue to complete overleaf

5) **Diabetic status** Have you been diagnosed with Diabetes? **YES/NO**

If yes, please circle as appropriate:

a) **Type 1-** Currently on Insulin/ Not on insulin

b) **Type 2-** Currently on Insulin/ Not on insulin

c) **Gestational-** Currently on Insulin/ Not on insulin

6) **Ethnicity**

Please choose **one** of the options below:

A. UK White	
B. N European White (Denmark, Estonia, Finland, Iceland, Latvia, Lithuania, Norway, Sweden)	
C. S or other European White (all other European countries, inc. Cyprus, Turkey)	
D. Other non-European White (Australia mainland, N America, white S Africa, Russia)	
E. Mixed White (mix of any of the above white ethnicities)	
F. Black African or Caribbean (Caribbean islands, black African, any other black background)	
G. East Asian (China, Mongolia, North/South Korea, Japan, Hong Kong, Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Singapore, Thailand, Timor Leste, Vietnam)	
H. South Asian (India, Pakistan, Bangladesh, Nepal, Maldives)	
I. White and Asian	
J. Mixed black ethnicity	
K. Mixed other ethnicity	

6a) Country (Please specify): ……

Thank you for taking the time completing this form

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PART B- For Sonographer use only

1) Has the service user already received a screening result in this pregnancy (i.e. Harmony, NIPT etc)? **YES/NO**

2) Is there a requirement to contact the ANNB Screening team prior to the ultrasound scan (i.e. twin pregnancy, previous pregnancy affected by T21/T18 or T13 etc? **YES/NO**

The service user would like screening for…

	Please indicate one option below
Downs, Edwards' and Patau's syndromes (T21, T18 and T13)	
Downs syndrome (T21) only	
Edwards' and Patau's syndromes (T18/T13)	
Screening Declined	

Patient's Signature: …… Date: ……

<u>Following completion of the ultrasound scan (if combined screening not achieved)</u>

- Has the service user consented to the Quadruple screening test? **YES/NO**

Sonographer Signature: …… Date: ……