Sequential Screening

Patient Name: _____ DOB: _____

The Sequential Screen is a two-step test.

1st step: Ultrasound to measure fluid behind the baby's neck (Nuchal Translucency) and blood test between 10-14 weeks

--Ultrasound image sometimes cannot be obtained due to the fetus having to be in a very specific position.

--We can try to reschedule a 2nd attempt ultrasound at a later date but if the images again are unable to be obtained, you can select an alternative screening test or a referral to maternal fetal specialist for further evaluation.

2nd step: blood test performed between 15-22 weeks

--final result of testing will be resulted after the 2nd step is complete.

Sequential screening is used to screen for abnormal chromosomes such as Down syndrome (Trisomy 21) and Patau syndrome (Trisomy 18) and also defects of the brain and spine called neural tube defects, and some defects of the abdomen, heart and face.

If an abnormal measurement is noted on ultrasound during the first step or the final result after the second step is abnormal, we will refer you to the high-risk pregnancy specialist (Perinatologist/Maternal Fetal Medicine) because your fetus is at higher risk of having a disorder compared with the general population. It **does NOT** mean that your fetus DEFINITELY has a disorder. They will perform a detailed ultrasound and offer you the option of diagnostic testing with *CVS or amniocentesis*, which are diagnostic tests that will tell if your baby actually has the disorder.

A **negative** screening test result means that your fetus is at a lower risk of having a disorder compared with the general population. It **does NOT** completely rule out the possibility that your fetus has a disorder.

***These screening tests could result in a false-positive result (shows there is a problem when there isn't one) or a false-negative result (shows there is not a problem when there is one). It is important to remember that a screening test can never completely rule out the chance of the baby having any birth defects.

_____ I do want the Sequential Screening testing

_____ I do <u>NOT</u> want the Sequential Screening testing

Signature of Patient: _____Date: _____

Signature of Provider: _____ Date: _____