

# Nuchal Translucency Ultrasound

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

A NT (Nuchal translucency) ultrasound is the 1<sup>st</sup> step of the Sequential Screen. This is performed to measure the fluid behind the baby's neck between 11 weeks and 13 6/7 weeks of pregnancy.

- If the ultrasound images are successful, blood work will be performed usually the same day.
- However, ultrasound images sometimes cannot be obtained due to the fetus having to be in a very specific position.
- We can try to reschedule a 2<sup>nd</sup> attempt ultrasound at a later date, however, if the images again are unable to be obtained, you can select the alternative screening test in our office (MaterniT 21).
- Final results of this 2 step Sequential Screen will be complete after a 2<sup>nd</sup> blood draw in the 2<sup>nd</sup> trimester between 15-22 weeks.

## Abnormal results:

If an abnormal measurement is noted, we will refer you to a high-risk pregnancy specialist (Perinatologist/Maternal Fetal Medicine) because your fetus is at higher risk of having a disorder such as Trisomy 21 (Down Syndrome), or a heart, lung, brain, bowel or bone abnormality compared with the general population. It does **NOT** mean that your fetus DEFINITELY has a disorder. They will perform further detailed ultrasounds and offer you the option of diagnostic testing with chorionic villus sampling (CVS) or amniocentesis, which can tell the actual chromosomes of the baby.

A **negative** screening test results 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.

**BILLING:** The costs of ALL ultrasounds are the patient's responsibility even if the images are not successful. It is the responsibility of the patient to verify insurance coverage for the above test desired.

\_\_\_\_\_ I do want the Nuchal Translucency ultrasound

\_\_\_\_\_ I do NOT want the Nuchal Translucency ultrasound

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Provider: \_\_\_\_\_ Date: \_\_\_\_\_