1. Last Name			First Name							MI
2. Patient Number										
3. Date of Birth (MM/DD/YYYY)										
			Month		Day			Year		
4. Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ White ☐ Other _____										
5. Ethnic Origin ☐ Hispanic Cuban ☐ Hispanic Mexican American ☐ Hispanic Other ☐ Hispanic Puerto Rican ☐ Not Hispanic/Latino ☐ Unreported										
6. Gender ☐ Female ☐ Male										
7. County of Residence										

N.C. Department of Health and Human Services
Division of Public Health
Women Infant and Community Wellness Section

MATERNAL HEALTH LABORATORY DATA

(See Instructions)

Initial Labs	Date	Result	Reviewed Date/Initials	Comments/Additional Labs
Blood Type	/ /	☐ A ☐ B ☐ AB ☐ O		
D (Rh) Type	/ /			
Antibody Screen	/ /			
HCT/HGB	/ /	_____% _____g/dL		
Pap Smear (if indicated)* Date of last Pap prior to this pregnancy	/ /			
Rubella Titer	/ /			
Varicella Titer	/ /			
Syphilis Screen	/ /			
Urine Culture for GBS	/ /			
HBsAg	/ /			☐ **Positive Results Reported to Communicable Disease Nurse within 24 hours**
Hepatitis C screening	/ /			
HIV (Initial)	/ /	☐ Pos. ☐ Neg. ☐ Declined		
HGB Electrophoresis (if indicated)	/ /	☐ Declined		**HGB Electrophoresis of FOB (if indicated)** **Date:_____ Results_____ ☐ Declined**
Cystic Fibrosis (if indicated)	/ /	☐ Declined		
1st trimester genetic screening (if indicated)	/ /	☐ Declined		
PPD (if indicated)	/ /			
Chlamydia	/ /			
GC	/ /			
Early Diabetes Screen	/ /			
Other	/ /			
15–20 Week Labs	**Date**	**Result**	**Date/Initials**	
Multi Markers/Quadruple Serum Screen (optimally before 20 weeks)	/ /	☐ Declined		
Other	/ /			
24–28 Week Labs	**Date**	**Result**	**Date/Initials**	
HCT/HGB (if indicated)	/ /	_____% _____g/dL		
Diabetes Screen	/ /	1 hour _____		
2 or 3 hour GTT (if indicated)	/ /	___ FBS ____ 1 hour ___ 2 hours ____ 3 hours		
Other	/ /			
28–30 Week Labs	**Date**	**Result**	**Date/Initials**	
Syphilis Screen	/ /			
D (Rh) Antibody Screen (if indicated)	/ /			
D Immune Globulin (RhIG) given (28 wks) (if indicated)	/ /	Lot #_____ Signature:_____		
3rd Trimester HIV (anytime between 28–36 wks)**	/ /	☐ Pos. ☐ Neg. ☐ Declined		
Other	/ /			
32–37 Week Labs	**Date**	**Result**	**Date/Initials**	
HCT/HGB	/ /	_____% _____g/dL		
GC (if <25 y.o. or ≥ 25 y.o. and in high risk behavior)	/ /			
Chlamydia (if <25 y.o. or ≥ 25 y.o. and in high risk behavior)	/ /			
Group B strep (36–38 wks as Indicated)***	/ /			
Other	/ /			

DHHS 4010 (Reviewed 09/2022)
WCHS Review (09/2025)

* Refer to the latest ASCCP or ACOG pap smear guidelines. ** 3rd Trimester HIV preferably before 36 wks
*** GBS culture not repeated if diagnosed with GBS bacteria during current pregnancy. Please document GBS on problem list.

Instructions for Maternal Health Laboratory Data

Purpose: To assess, document and evaluate health related information on the prenatal patient.

Instructions: Laboratory Tests/Screenings

- In the first column, the laboratory data is divided into time specific sections to serve as a prompt for initiation and completion of the “required” (initial and repeat), “as indicated”, and “other” laboratory tests/ screenings.
- The DATE should be documented indicating the date that the laboratory sample is collected or the test is performed.
- The RESULT column provides space for documentation of the results of the laboratory/screening test. If the laboratory results choices are listed, circle the appropriate result. If they are not listed, write in the result as appropriate.
- Note that in the RESULT column that corresponds to HIV, HGB Electrophoresis, Cystic Fibrosis, and Quadruple Screen, there is a block to indicate whether the client refused the test/screening. As appropriate, indicate client refusal by placing a check mark in the corresponding block.
- Note that at the end of each time interval section, there is an opportunity to document “other” test/screening that may be indicated. There is also space in the large column headed COMMENTS/ADDITIONAL LABS to document additional labs.
- In the REVIEWED column, document the date the result was reviewed with the client and the initials of the person providing the review.
- In the COMMENTS/ADDITIONAL LABS column, document any additional labs not indicated in the first column. This column also provides the opportunity for comments related to the laboratory test/screening. Signature of person making comments entry should be documented.
- Note that in the 28–30 Week Labs section, there is space for documenting the administration of D Immune Globulin (RhIG) at 28 wks, if indicated. The signature of the person administering this should be documented at the designated place in the RESULT column.
- Note that in the third trimester Gonorrhea and Chlamydia is repeated to everyone less then 25 years old (State law — 10A NCAC 41A .0204) or to anyone 25 years old or older and practicing risky sexual behaviors (multiple partner, new partner, substance use, limited prenatal care, etc).

Disposition: This form is to be retained in accordance with the records disposition schedule of medical records as issued by the Division of Archives and History.

Location: Go to the following link to access this form and print as needed:
https://wicws.dph.ncdhhs.gov/provPart/forms.htm