UR MEDICINE | Labs

# Specimens:			Depot:
Collect Date:	Time:	By:	ABN Signed: ☐
MR #:		A #:	

REQUIRED (PRINT OR PATIENT LABEL)

Name(Last, First, MI)

Date of Birth | Sex:(circle) M F

Street Address

Street Address 2

City, State, Zip

Phone Number | Chart Number

Indicate primary (1) and secondary (2) insurance

___ Blue Choice/Shield ___ Child Health Plus ___ MVP
___ Blue Choice ___ Medicaid ___ MVP Gold
___ Blue Choice Medicare ___ Medicare ___ Aetna
___ Other: _____

1. Subscriber ID: _____
Subscriber's Name: _____
Relationship to Subscriber: _____
2. Secondary Subscriber ID: _____
Subscriber's Name: _____
Relationship to Subscriber: _____

_____
_____
_____ , _____ , _____

[Address]
SEE ATTACHED REQ

Phone: Fax:

☐ (Doctor): _____

Phone Results to: Fax Results to:

Ordering Provider's Signature Date of Signature

Diagnosis Mandatory: Signs/Symptoms or ICD10 Codes
If ordered for screening, list test name here and write "SCREENING" after it

Send Additional Reports To: (Full Name/Address)

Compliance is Mandatory and Regulated. For the laboratory to bill properly and receive payment for tests ordered on Medicare Beneficiaries, specific ICD-10 code(s) or a descriptive diagnosis must be included on each patient for each test ordered.It is critical that the diagnosis provided to the lab is consistent with those recorded in the patient medical record on the date of service.

REQUIRED FIELDS FOR RESULT REPORTING:

Patient's weight _____lbs OR _____kgs
Due date (EDC) _____ Determined by: ☐ Ultrasound
☐ Last menstrual period, confirmed by ultrasound
☐ Last menstrual period. Date: _____

Additional Information (Required ultrasound information for First Trimester screen.)

Ultra sound date: _____ **ALL TESTS: Obtain NT when CRL is 38-83.9mm**
Sonographer's Name: _____ FMF or NTQR Certification #: _____
Reading MD Name: _____ FMF or NTQR Certification #: _____
CRL (mm): _____ NT (mm): _____ Twin B CRL (mm): _____ Twin B NT (mm): _____

Number of fetuses?
☐ Singleton ☐ Twins ☐ Unknown

Patient's race?
☐ Non-Black ☐ Black ☐ Unknown

Was the patient diabetic at the time of conception?
☐ No ☐ Yes

Does the patient currently smoke cigarettes?
☐ No ☐ Yes

ADDITIONAL INFORMATION:
For twins, is pregnancy monochorionic? ☐ No ☐ Yes ☐ Unknown

Is this an in vitro fertilization pregnancy?
☐ No ☐ Yes ☐ Unknown

Has the patient had a previous maternal serum screen in this pregnancy?
☐ No ☐ Yes ☐ Unknown

Has the patient taken valproic acid or carbamazepine during this pregnancy?
☐ No ☐ Yes; specify medication: _____

Has the patient had a previous pregnancy with trisomy? (i.e., Down syndrome, trisomy 18 or 13)
☐ No ☐ Yes; specify abnormality: _____

Is there a family history of neural tube defects? (i.e., spina bifida, anencephaly, encephalocele)
☐ No ☐ Yes; specify the relationship of the affected individual to the fetus: _____

SELECT THE TEST YOU INTEND TO ORDER:

MSSQA ☐ **3000143 Maternal Serum Screen Quad**
MSSAF ☐ **3000144 Maternal Serum Screen AFP**
MSSFT ☐ **3000145 Maternal Serum Screen First Trimester**

Perform blood draws when CRL is within the appropriate range:
First Trimester: CRL 43 | 83.9mm

PATIENT CONSENT

I have read the information on the back of this form and discussed it with my health care provider. My questions about Prenatal Screening have been answered. I am aware that this testing is widely accepted as a screening test for birth defects, but that it may not yet be endorsed by New York State. I authorize withdrawal and analysis of the necessary blood sample.I also authorize the UR Medicine Clinical Laboratories and the Rochester Regional Genetics Program to release my test results to my health care provider. I authorize follow up information about this pregnancy, as required by New York State, to be released confidentially to the Rochester Regional Genetics program. I agree that the serum which remains after results are completed may be used anonymously to develop techniques for prenatal diagnosis.

Patient/Legal Guardian: Date: ____ /____ /_____ Health Care Provider: