URMC 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 | Client Number

Indicate primary (1) and secondary (2) insurance

__Blue Cross/Shield __Child Health Plus __MVP

__Blue Choice __Medicaid __MVPG

_Medicare Blue Choice __Medicare __Aetna

__Other _____

1. Primary Contract #: _____

Subscriber's Name: _____

Relationship to Subscriber: _____

2. Secondary Contract # _____

Subscriber's Name: _____

Relationship to Subscriber:

Practice Name _____

Address _____

Address2 _____

City, State, Zip _____

Phone# _____

Ordering Provider _____

Phone Results to: Fax Results to:

Diagnosis Mandatory: Signs/Symptoms or ICD9 Code

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-9 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.

TEST REQUESTED (REQUIRED)

46454 ☐ First Trimester Screen (11-13 6/7 Weeks)

46405 ☐ 2nd Trimester AFP+ (Quad) Screen (14-22 6/7 Weeks) (AFP, uE3, hCG, Inhibin A)

33808 ☐ MATERNAL AFP ONLY (14-22 6/7 Weeks) for: ***(CHECK ONE)*** ☐ Repeat AFP ☐ First Screen Follow-up ☐ CVS Follow-up

CLINICAL INFORMATION*(ALL INFORMATION MUST BE COMPLETED)*

Race: ☐ Black ☐ White Other _____

Is Patient currently Diabetic? ☐ NO ☐ YES

REQUIRED Current Weight: _____ *SELECT ONE* ☐ (LBS) ☐ (KGS)

Date: _____

Previous Pregnancy with:

☐ Down Syndrome ☐ Neural Tube Defect ☐ Other _____

Date of LMP ____ / ____ / ____

Date of Ultrasound (US) ____ / ____ / ____

Ultrasound Gestational Age on above date ____ **Wks** ____ **Days** **(by BPD. if available)**

Physical Exam (If no other dating available) ____ **Wks on** ____ **Date**

If IVF, Date of IVF _____ Egg Donor Age (if applicable) _____

If Multiple Gestation, Number of Fetuses: _____

1ST TRIMESTER SCREEN ULTRASOUND INFORMATION

NT and Nasal Bone Information **MUST** be Performed by NT Certified/Nasal Bone Educated Sonographer Only

US Date: ____ / ____ / ____ Location _____

Sonographer Name: _____

Sonographer Certification #: _____

Supervisor Name: _____

Supervisor Certification #: _____

(Single Gestation) NT ____ mm CRL ____ mm

Nasal Bone: Present ☐ Absent ☐ Unknown ☐

(Twin, If Applicable) NT ____ mm CRL ____ mm

Nasal Bone: Present ☐ Absent ☐ Unknown ☐

Chorionicity: _____

PATIENT REFUSAL (FOR PROVIDERS RECORDS)

I have been informed of the purpose and availability of Prenatal Screening and my questions about it have been answered. I choose NOT to have:

Check those that apply ☐ 1st Trimester Screening ☐ 2nd Trimester AFP + (QUAD) Screening ☐ 2nd Trimester MATERNAL AFP ONLY Screening

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

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 Strong Health 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:

URMC PRENATAL SCREENING PROGRAM

Prenatal Screening Information for Consent

Patient Name_____ Date of birth _____

1. 1ST TRIMESTER SCREENING (Must be done between 11 to 13 6/7 weeks of pregnancy)
*** Tells how high the chance is that the baby has Down syndrome or Trisomy 18***

1st Trimester Screening combines ultrasound measurements of the skin at the back of the baby's neck (the Nuchal Translucency or "NT") and the baby's nasal bone with a blood test to measure two substances (hCG and PAPP-A) normally found in the pregnant woman's blood. It is normal for the NT measurement to vary among healthy fetuses, and for the hCG and PAPP-A levels to vary in normal pregnancies. But if the NT measures larger than average, or the hCG or PAPP-A are high or low, the risk for chromosome problems like Down syndrome may be increased. If 1st Trimester Screening shows a high enough risk, the woman can choose an additional test like amniocentesis or chorionic villus sampling (CVS) to tell for sure if the baby has normal chromosomes. In some cases, 1st Trimester Screening may indicate that the baby's chance for a chromosome problem is low enough that a woman who was planning to have amniocentesis or CVS might choose not to have it.1st Trimester Screening screens for:

Down Syndrome - Down syndrome is caused by an extra 21st chromosome. It results in moderate mental retardation, some physical differences and sometimes health problems such as heart defects. Children with Down syndrome have special education needs, but often these are arranged through their regular school.

Trisomy 18 - Trisomy 18 is caused by an extra 18th chromosome. It is a very severe birth defect causing many health problems and severe mental retardation. Nine out of ten babies born with Trisomy 18 do not survive beyond one year of life.

1st Trimester Screening identifies about 85% of pregnancies where the baby has Down syndrome or Trisomy 18, however in about 15% of pregnancies with these conditions, the screening result is normal. 1st Trimester Screening does not screen for Neural Tube Defects or other open fetal defects. An AFP ONLY test can be done after 14 weeks of pregnancy to screen for these.

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2. 2nd TRIMESTER AFP+ SCREENING (Also called the **"Quad Screen"** -Must be done after 14 weeks of pregnancy)
Tells how high the chance is for Down syndrome, Trisomy 18, or Spina bifida and other open fetal defects

AFP+ Screening is a blood test that measures the levels of four substances (AFP, Unconjugated Estriol, hCG, and Inhibin-A) in a pregnant woman's blood. It is normal for the levels of these to vary among different women, but women with particularly high or low values may be at increased risk to have a baby with certain birth defects. AFP+ Screening is usually done between 15-18 weeks of pregnancy. The AFP+ Quad Screen test screens for:

Down Syndrome - Down syndrome is caused by an extra 21st chromosome. It results in moderate mental retardation, some physical differences and sometimes health problems such as heart defects. Children with Down syndrome have special education needs, but often these are arranged through their regular school.

Trisomy 18 - Trisomy 18 is caused by an extra 18th chromosome. It is a very severe birth defect causing many health problems and severe mental retardation. Nine out of ten babies born with Trisomy 18 do not survive beyond one year of life.

Neural Tube Defects (spina bifida and anencephaly) - Neural tube defects are birth defects where the brain (anencephaly) or part of the spinal cord (spina bifida) does not form normally and may not be covered with skin or bone. Babies with anencephaly are usually stillborn or die shortly after birth. Babies with spina bifida usually have medical problems including leg paralysis, impaired bowel and bladder control, "water on the brain", and sometimes learning problems.

Abdominal Wall Defects - These birth defects are caused by an opening in the layer of muscle and skin near the "belly button". Although serious, they can often be corrected with surgery.

AFP+ Screening identifies about 75-80% of pregnancies where the baby has Down syndrome, and about 60% of pregnancies with Trisomy 18. About 90% of pregnancies with spina bifida or other open fetal defects are identified by AFP+ Screening.

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3. 2nd TRIMESTER AFP ONLY SCREENING (Must be done after 14 weeks of pregnancy)
Tells how high the chance is for Spina bifida and other open fetal defects. Does NOT screen for Down syndrome or Trisomy 18

AFP ONLY Screening is a blood test that measures the level of AFP in a woman's blood. It should be ordered only in cases where a woman has already had 1st Trimester screening or CVS, or if it is recommended after a Quad screen has shown a mild AFP elevation.

What are "Screening" Tests?

1st Trimester Screening, AFP+ Screening, and AFP ONLY are "screening" tests because they cannot tell for sure whether the fetus does or does not have a birth defect. But they can tell if there is a greater than average risk that the baby has certain birth defects. Further testing (like ultrasound or amniocentesis) can be done to tell with greater certainty if a birth defect is or is not present. About 7% of women who have a screening test will be offered further testing, and most of the time these follow up tests will show that the baby is healthy.

Please sign on the front side of this form