



PSRXXXXXXXXX

PRENATAL SCREEN REQUISITION
CLIENT INFORMATION

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name	First	MI
Address	Birth Date	Sex <input type="checkbox"/> M <input type="checkbox"/> F
City	SS #	
ST	ZIP	Home Phone
Physician Office Patient ID#	CC MRN:	

INSURANCE BILLING INFORMATION (PLEASE PRINT IN BLACK INK)

BILL TO: Client Patient Insurance (Complete Insurance Information below)

ABN Yes No **WORKERS COMP:** Yes No DOI: _____

PRIMARY Medicare Medicaid Other Ins. _____ Self Spouse Child

Subscriber Last Name	First	MI
Beneficiary / Member #	Group #	
Claims Address	City	ST ZIP

SECONDARY Medicare Medicaid Other Ins. _____ Self Spouse Child

Subscriber Last Name	First	MI
Beneficiary / Member #	Group #	
Claims Address	City	ST ZIP

Diagnosis Code 1. _____ 2. _____
REQUIRED 3. _____ 4. _____

Call results to Phone No: (_____) _____
 Fax report to: (_____) _____

PHYSICIAN SIGNATURE REQUIRED

Physician Signature	Date / Time
Physician Print Name	NPI#
Date collected: ____ / ____ / ____ Time: _____	
Collected by: _____	
Specimen Type: <input type="checkbox"/> Serum <input type="checkbox"/> Amniotic Fluid	
<input type="checkbox"/> Send additional report	
Physician: _____	
Address: _____	
City, State, Zip: _____	

Test Request

- | | |
|---|---|
| AFPTRI <input type="checkbox"/> Triple Marker (Alpha-Fetoprotein, HCG, Estriol) | AFPMAT <input type="checkbox"/> Alpha-Fetoprotein, Maternal (Serum) |
| QUAD4 <input type="checkbox"/> Quad Marker (Alpha-Fetoprotein, HCG, Estriol, Inhibin) | FAFPAM <input type="checkbox"/> Alpha-Fetoprotein (Amniotic Fluid) |

THE FOLLOWING INFORMATION IS REQUIRED AND MUST ACCOMPANY 2 ML OF SERUM OR AMNIOTIC FLUID

Draw Date: _____ Date of Birth: ____ / ____ / ____	For Internal Lab Use Only
Race: <input type="checkbox"/> White <input type="checkbox"/> African-American <input type="checkbox"/> Other _____	
Is patient an insulin-dependent diabetic: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pregnancy is: <input type="checkbox"/> Single <input type="checkbox"/> Twins <input type="checkbox"/> Triplets Weight: _____ lbs	
Is there a family history of neural tube defect (NTD): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, relationship to patient: _____	

AFP=
HCG=
UE3=
DIA=
LOG#

ESTIMATION OF GESTATIONAL AGE (Please complete the appropriate boxes below.)

- | | |
|---|---|
| a) Last Menstrual Period: ____ / ____ / ____ | Gestational Age Estimate On Date of Ultrasound: _____ Weeks |
| b) Ultrasound Date: ____ / ____ / ____ | Gestational Age Estimate on Date of Physical Exam: _____ Weeks |
| c) Physical Exam Date: ____ / ____ / ____ | Method of EDD: <input type="checkbox"/> LMP <input type="checkbox"/> US <input type="checkbox"/> PE (Check One) |
| d) Estimated Date of Delivery: ____ / ____ / ____ | |

Is this an IVF or infertility pregnancy: Yes No Is this a repeat sample: Yes No

Reason for Referral: Routine Prenatal Screen
 Abnormal Ultrasound
 Elevated Low AFP in Serum (Check One)
 Other (Specify): _____



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