

**SHODAIR CHILDREN'S HOSPITAL GENETICS LABORATORY**

2755 Colonial Drive, PO Box 5539, Helena, MT, 59604

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# SECOND TRIMESTER MATERNAL SERUM SCREENING

*(Please send this completed form with the specimen)*

PATIENT LAST NAME: \_\_\_\_\_ FIRST NAME : \_\_\_\_\_ SOC. SEC. #: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ SEX: F DATE COLLECTED: \_\_\_/\_\_\_/\_\_\_ DATE RECEIVED: \_\_\_/\_\_\_/\_\_\_

Resp. Party (Relation to Pt): \_\_\_\_\_ Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**REFERRING PHYSICIAN/ HEALTH PROFESSIONAL:**

Physician's Signature and date:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Telephone: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_

**REFERRING INSTITUTION / CLINIC / LABORATORY:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Telephone: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_

**ADDITIONAL REPORTS TO:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Telephone: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_

**BILLING INFORMATION: (Check)**

**REFERRING INSTITUTION / CLINIC / OFFICE**  
Institution Name: \_\_\_\_\_ Inpatient: Yes No  
Billing Address: \_\_\_\_\_  
Financial Contact: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

**INSURANCE**  
**Commercial: Provide front / back copy of card**  
**Managed Care (HMO): Copy of card with authorization**  
**Medicaid (MT, WY, CO, UT, CA, ID): Copy of card**

Name of Policy Holder: \_\_\_\_\_

Insurance Co / Policy #: \_\_\_\_\_

Group# \_\_\_\_\_

Insurance Co Contact / Phone #: \_\_\_\_\_

**SS # (Guarantor):** \_\_\_\_\_

Medicaid # / State: \_\_\_\_\_

**SELF PAY** (Please call the laboratory to arrange)

**TEST REQUESTED: Please check one box (Draw sample between 15 to 22 weeks gestation)**

- Triple Screen (AFP, hCG, uE3) CPT CODES: 82105, 84702, 82677**
- Quad Screen (AFP, hCG, uE3, Inhibin A) CPT CODES: 82105, 84702, 82677, 86336**
- AFP only (post CVS or first trimester screen) CPT CODE: 82105**

**RISK CALCULATION IS BASED ON ACCURATE PREGNANCY INFORMATION**

Ultrasound Date (if done): \_\_\_\_\_

Gestational Age at Time of U/S: \_\_\_\_\_ weeks \_\_\_\_\_ days

LMP Date: \_\_\_\_\_ EDD: \_\_\_\_\_

Maternal Weight: \_\_\_\_\_ lbs. Maternal Race: \_\_\_\_\_

Date Collected: \_\_\_\_\_ G \_\_\_ P \_\_\_ Ab \_\_\_

Where Collected (facility): \_\_\_\_\_

Was this an IVF/ART Pregnancy?  YES  NO

-- date of Embryo Transfer \_\_\_\_\_

Donor Egg used?  YES  NO

-- if YES, donor age or donor date of birth \_\_\_\_\_

If over 35 years, is this the first pregnancy?  YES  NO

IDDM (prior to pregnancy)?  YES  NO

Carrying Twins?  YES  NO

Previous NTD?  YES  NO; Previous Down's?  YES  NO

Repeat Specimen?  YES  NO