

PRENATAL AND FETAL LOSS TEST REQUEST FORM

(Please send this completed form with the specimen)

PATIENT LAST NAME: _____ FIRST NAME : _____ DOB: _____
 SEX: M / F REF. LAB #: _____ DATE COLLECTED: _____ DATE RECEIVED: _____
 ETHNIC BACKGROUND: (Circle all that apply) European Caucasian, Hispanic, Native American, African American, Asian, Other

REFERRING PHYSICIAN/ HEALTH PROFESSIONAL: Name: _____ Address: _____ City, State, Zip: _____ Telephone:(____) _____ FAX:(____) _____	REFERRING INSTITUTION / CLINIC / LABORATORY: Name: _____ ADDITIONAL REPORTS TO: Name: _____
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PHYSICIAN SIGNATURE: _____ **Date:** _____
 (required for Medicare / Medicaid billing)

BILLING INFORMATION: <input type="checkbox"/> REFERRING INSTITUTION New clients please call laboratory with financial contact information.	<input type="checkbox"/> INSURANCE Name of policy holder: _____ Policy holder DOB: _____ SS # (Guarantor): _____ Address: _____ Phone #: _____ Relationship to patient: _____ Insurance Co. / Policy #: _____ Insurance Co Contact / Phone #: _____	<input type="checkbox"/> Medicaid #: _____ State (MT, WY, CO, UT): _____ SS#: _____ <input type="checkbox"/> SELF PAY <input type="checkbox"/> Inpatient
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INDICATION FOR ANALYSIS:

Possible/Probable diagnosis: list symptoms ICD-9 Codes:

PRENATAL INFORMATION

LMP: _____ Pregnancy wks by U/S: _____
 G _____ P _____ Ab _____ Date of U/S: _____

Family History/Reason for Referral:

Advanced maternal age Family History
 At risk serum screen Previous child with abnormality
 Ultrasound abnormality Other: _____

SPECIMEN TYPE: (Please check) PLEASE NOTIFY THE LABORATORY WHEN A SPECIMEN IS BEING SENT. 1-800-447-6614, EXT. 7532

Amniocentesis Fresh tissue: POC, fetal, other, source: _____ PUBS
 CVS

Please submit 3-5 ml maternal blood collected in an EDTA tube for maternal cell contamination study. We strongly recommend this test when chorionic villus samples results indicate a female fetus (we discard the sample if the results are male). If you do not choose to submit this sample, please check the box below which assures that you have discussed this testing with the patient and she declines this additional testing.

Decline

TEST REQUESTED: (Please check one or more; test descriptions with CPT codes and prices faxed on request).

<input type="checkbox"/> Chromosomes / AFP	<input type="checkbox"/> Chromosomes / AFP + Direct FISH Interphase Aneuploidy for 13, 18, 21, X, Y	<input type="checkbox"/> Chromosomes / AFP + FISH-other	<input type="checkbox"/> Fetal Loss (POC) Evaluation <input type="checkbox"/> Autopsy <input type="checkbox"/> Cytogenetics <input type="checkbox"/> Other: _____
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Date Set Up: _____	Med. Rec. # _____	Admit # _____	Shire # _____
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