

SHODAIR LAB #:

PRENATAL AND FETAL LOSS TEST REQUEST FORM

(Please send this completed form with the specimen)

PATIENT LAST NAME: _____ FIRST NAME : _____ SOC. SEC. #: _____
 DOB: ___/___/___ SEX: M / F / Unk REF. LAB #: _____ DATE COLLECTED: ___/___/___ DATE RECEIVED: ___/___/___
 Resp. Party (Relation to Pt): _____ Address: _____ Phone: (____) _____
 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: _____ Address: _____ City, State, Zip: _____ Telephone: (____) _____ FAX: (____) _____ ADDITIONAL REPORTS TO: Name: _____ Address: _____ City, State, Zip: _____ Telephone: (____) _____ FAX: (____) _____	BILLING INFORMATION: (Check) <input type="checkbox"/> REFERRING INSTITUTION / CLINIC / OFFICE Institution Name: _____ Inpatient: Yes No Billing Address: _____ Financial Contact: _____ Telephone: (____) _____ <input type="checkbox"/> 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 #: _____ Insurance Co Contact / Phone #: _____ SS # (Guarantor): _____ Medicaid # / State: _____ <input type="checkbox"/> SELF PAY (Please call the laboratory to arrange)
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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:

<input type="checkbox"/> Advanced maternal age	<input type="checkbox"/> Family History
<input type="checkbox"/> At risk serum screen	<input type="checkbox"/> Previous child with abnormality
<input type="checkbox"/> Ultrasound abnormality	<input type="checkbox"/> Other: _____

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

<input type="checkbox"/> Amniocentesis	<input type="checkbox"/> Fresh tissue: POC, fetal, other, source: _____
<input type="checkbox"/> CVS	<input type="checkbox"/> PUBS

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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LAB USE ONLY:

Date Collected: ___/___/___	Med. Rec. # _____	Lab # _____
Date Received: ___/___/___	Admit # _____	
Date Set Up: ___/___/___	Shire # _____	