

**SHODAIR CHILDREN'S HOSPITAL GENETICS LABORATORY**

2755 Colonial Drive, PO Box 5539, Helena, MT, 59604 (406) 444-7535, (800) 447-6614

Fax: (406) 444-1022, Email: mtgene@shodair.org

SHODAIR LAB #:

**SERUM INTEGRATED SCREEN**

(NT measurement is not required.)

(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:**

PAPP-A (collect sample at 10-13 weeks gestation) CPT CODE : 84163

Quad Test (collect sample at 15-22 weeks gestation) CPT CODES: 82105, 84702, 82677, 86336

**RISK CALCULATION IS BASED ON ACCURATE PREGNANCY INFORMATION (LMP DATING IS NOT ADVISED)**

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

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

Previous NTD?  YES  NO

Previous Down's?  YES  NO

Was this an IVF/ART Pregnancy?  YES  NO Donor Egg used?  YES  NO – If YES, donor age at donation \_\_\_\_\_

Carrying Twins  YES  NO

Insulin-Dependent Diabetic (prior to pregnancy)?  YES  NO

G \_\_\_\_\_ P \_\_\_\_\_ Ab \_\_\_\_\_

Repeat specimen ?  YES  NO