



# Montana's Medical Genetics Program

2755 Colonial Drive, PO Box 5539, Helena, MT 59604  
(406) 444-7500 1-800-447-6614 FAX (406) 444-1022

Referring Physician _____
Name _____
Address _____
City/State/Zip _____
Phone _____
FAX _____
Referring Hospital/Clinic Name _____
Duplicate Reports to: _____

## Second Trimester Maternal Serum Screening

- Test Ordered:**
- Triple Screen (AFP, hCG, uE3)
  - Quad Screen (AFP, hCG, uE3, Inhibin A)
  - AFP only (post CVS or first trimester screen)

### PATIENT INFORMATION:

Patient's Last Name \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Birth Date \_\_\_\_\_

Social Security # (required) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Patient Marital Status  Married  Single Spouse or Parent Name (if patient is a minor) \_\_\_\_\_

Revised 7/06

### 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: \_\_\_\_\_ 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

Post CVS?  YES  NO

Repeat Specimen?  YES  NO

<b>BILLING INFORMATION:</b> (fill out completely)
Insurance Co. Name _____ Insurance Co. Phone _____
Street Address _____ City _____ State _____ Zip _____
Policy Number _____ Group # _____ Employer's Name _____
Name of Subscriber _____ SS# of Subscriber (required) _____
Address of Insured, if different from Patient _____
Marital Status of Subscriber <input type="checkbox"/> Married <input type="checkbox"/> Single
Insured Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other
*Please attach secondary insurance information forms.
<b>METHOD OF PAYMENT:</b> (please bill):
<input type="checkbox"/> Patient <input type="checkbox"/> Client/Institution
<input type="checkbox"/> Medicaid/Medicare* <input type="checkbox"/> Insurance*
<input type="checkbox"/> Payment Enclosed
*Attach legible copies of front and back of all ID cards.

I authorize payment of insurance benefits to Shodair Children's Hospital. I understand I am financially responsible for charges not covered by insurance listed above.

Signature of Patient/Guarantor: \_\_\_\_\_

Please submit white and yellow copies with specimen. Pink is sender's copy.