

SHODAIR LAB #:

SERUM INTEGRATED SCREEN

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

PAPP-A (collect sample at 10-13 weeks)

Quad Test (collect sample at 15-22 weeks)

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
 METHOD OF ULTRASOUND: CRL (1st trimester) _____ MM BPD (2nd trimester) _____ MM
 NT Measurement: _____ MM If Twins, NT #2 _____ MM Sonographer's Name: _____
 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
 Collection Date: _____ G _____ P _____ Ab _____

LAB USE ONLY:

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