Cleveland Clinic
Laboratories

2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

☐ STAT

PRENATAL SCREEN REQUISITION

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name	First MI
Address	Birth Date Sex ☐ M ☐ F
City	SS #
State Zip	Home Phone
Hospital/Physician Office Patient ID #	Accession #

INSURANCE BILLING INFORMATION (PLEASE PRINT IN BLACK INK)

BILL TO: ☐ Client ☐ Patient ☐ Insurance **(Complete insurance information below)**

ABN ☐ Yes ☐ No **WORKERS COMP:** ☐ Yes ☐ No DOI: _____

PRIMARY: ☐ Medicare ☐ Medicaid ☐ Other Ins. _____ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name	First MI
Beneficiary / Member #	Group #
Claims Address City State Zip	

SECONDARY: ☐ Medicare ☐ Medicaid ☐ Other Ins. _____ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name	First MI
Beneficiary / Member #	Group #
Claims Address City State Zip	

DIAGNOSIS CODE (REQUIRED)

1. _____ 2. _____
3. _____ 4. _____

☐ Call results to phone number: (_____) _____

☐ Fax report to: (_____) _____

CLIENT INFORMATION

PHYSICIAN SIGNATURE REQUIRED

Physician Signature Date / Time

Physician Print Name NPI#

Date collected: ___/___/___ Time: _____

Collected by: _____

Specimen Type: ☐ Serum ☐ Plasma

☐ Urine - volume _____ #hours _____

☐ Whole Blood ☐ Other (specify) _____

☐ Fasting _____hours ☐ Non-fasting

☐ Send additional report

Physician: _____

Address: _____

City, State, Zip: _____

INDICATE TESTS REQUESTED

☐	AFPTRI	Triple Marker (Alpha-Fetoprotein, HCG, Estriol)	☐	AFPMAT	Alpha-Fetoprotein, Maternal (Serum)
☐	QUAD4	Quad Marker (Alpha-Fetoprotein, HCG, Estriol, Inhibin)	☐	FAFPAM	Alpha-Fetoprotein (Amniotic Fluid)

THE FOLLOWING INFORMATION IS REQUIRED AND MUST ACCOMPANY 2 mL OF SERUM OR AMNIOTIC FLUID

Draw Date: _____ / _____ / _____ Date of Birth: _____ / _____ / _____

Race: ☐ White ☐ African-American
☐ Other _____

Is patient an insulin-dependent diabetic?: ☐ Yes ☐ No

Pregnancy is: ☐ Single ☐ Twins ☐ Triplets Weight: _____lbs.

Is there a family history of neural tube defect (NTD)?:
☐ Yes ☐ No ☐ Unknown
If Yes, relationship to patient: _____

For Internal Lab Use Only

AFP=
HCG=
UE3=
DIA=
LOG#

ESTIMATION OF GESTATIONAL AGE (Please complete the appropriate boxes below.)

a) Last Menstrual Period: _____ / _____ / _____
b) Ultrasound Date: _____ / _____ / _____
c) Physical Exam Date: _____ / _____ / _____
d: Estimated Date of Delivery: _____ / _____ / _____

Gestational Age Estimate On Date of Ultrasound: _____ Weeks
Gestational Age Estimate On Date of Physical Exam: _____ Weeks
Method of EDD: ☐ LMP ☐ US ☐ PE (Check one)

Is this an IVF or infertility pregnancy?: ☐ Yes ☐ No

Is this a repeat sample?: ☐ Yes ☐ No

Reason for Referral: ☐ Routine Prenatal Screen
☐ Abnormal Ultrasound
☐ Elevated ☐ Low AFP in Serum (Check one)
☐ Other (Specify):_____

WHITE: Laboratory Copy YELLOW: Billing Copy PINK: Client Copy