Cleveland Clinic Laboratories

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

PRENATAL SCREEN REQUISITION

<<FORM_ID>>

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name | First | MI

Address | Birth Date

City | SS #

State | Zip | Home Phone

Hospital/Physician Office Patient ID # | Accession #

CLIENT INFORMATION

INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK)

BILL TO: ☐ Client/Institution ☐ Medicare ☐ Insurance (Complete insurance information below) ☐ Patient

PATIENT STATUS: ☐ Inpatient ☐ Outpatient ☐ Non-Hospital Patient Hospital discharge date: _____/_____/_____

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

Subscriber Last Name | First | MI

Beneficiary / Member # | Group #

Claims Address | City | State | Zip

SECONDARY: ☐ No ☐ Yes (if Yes, please attach)

ORDERING PHYSICIAN CONTACT

Physician Name

Physician NPI#

Physician Phone

Physician Email

☐ Call Results to phone number: (_____) _____

☐ Fax report to: (_____) _____

☐ Send additional report _____

INDICATE TESTS REQUIRED

☐ Quad Marker *QUAD4*
☐ Alpha-Fetoprotein, Maternal *AFPMAT*
☐ Alpha-Fetoprotein, Amniotic Fluid *FAFPAM*
☐ First Trimester Screening *FIRTSC*
☐ Sequential Screen, First Trimester *SEQL1*
☐ Integrated Screen, First Trimester *INTG1*

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

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

Is this a repeat sample? ☐ Yes ☐ No

RACE: ☐ White ☐ African-American ☐ Unknown ☐ Other _____

WEIGHT: _____ lbs **SMOKING:** ☐ Yes ☐ No

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: _____

Previous Down syndrome pregnancy? ☐ Yes ☐ No

Is this an IVF or infertility pregnancy? ☐ Yes ☐ No
If Yes, date of egg collection: _____/_____/_____
date of egg transfer: _____/_____/_____
egg donor's date of birth: _____/_____/_____

Were frozen eggs used? ☐ Yes ☐ No
If Yes, date of collection: _____/_____/_____
date of transfer: _____/_____/_____

LABEL

FOR INTERNAL LAB USE ONLY

MEASUREMENTS LABEL

ULTRASOUND INFORMATION (PLEASE COMPLETE THE APPROPRIATE BOXES BELOW)

Sonographer Name: _____

Sonographer Code: _____

Ultrasound Date: _____/_____/_____ Gestational Age: _____

LMP Date: _____/_____/_____

Estimated Date of Delivery: _____/_____/_____ by ☐ Ultrasound ☐ LMP ☐ PE

CRL-A (Crown Rump Length) _____ mm

NT-A (Nuchal Translucency) _____ mm

If Twins, CRL-B _____ mm NT-B _____ mm

Nasal Bone Present – A? ☐ Yes ☐ No

If Twins, Nasal Bone Present in B? ☐ Yes ☐ No

Reason for Referral:

☐ Routine Prenatal Screen
☐ Abnormal Ultrasound
☐ Elevated Risk
☐ Low AFP in Serum
☐ Other (specify) _____

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