

Expertise Delivered Personally

MLabs N-LNC Specimen Processing
 Department of Pathology & Clinical Laboratories
 2800 Plymouth Rd, Bldg 35
 Ann Arbor, MI 48109-2800
 734-936-2598 • 800-862-7284
 www.mlabs.umich.edu

Client	Patient Reg or MRN:		
	Patient Name: Last	First	MI
Ward	Birthdate:	Gender: OM OF	
	Ordering Doctor: Last	First	NPI#
	Ordering Doctor: Phone	Fax	
	Collected By	Collection Date	Collection Time Oam Opm

Patient Address	City	State	ZIP	Home Phone #
Policy Holders Name	Primary Insurance (Card Name)	Primary Policy/Contract #	Primary Group #	Policy Holders DOB
Policy Holders Name	Secondary Insurance (Card Name)	Secondary Policy/Contract #	Secondary Group #	Policy Holders DOB

Bill To: Client/Referring Institution Patient/Insurance

Medicare = In Patient on DOS Out Patient on DOS Non Patient on DOS

If patient or insurance information is not included or attached to this form, your facility will be billed. For Medicare patients classified as a hospital inpatient or outpatient on the date of service, charges must be billed to the referring client.

ICD-10 CODES

ICD-10 Codes are required for billing. When ordering tests for which reimbursement will be sought, order only tests that are medically necessary for the diagnosis and treatment of the patient.

PATIENT HISTORY/DIAGNOSIS – REQUIRED INFORMATION (FILL OUT COMPLETELY AND SEND WITH SAMPLE TO ENSURE TIMELY RESULTS.)

Name: _____ Date of Birth: _____ Weight _____ lbs (weight is **required** for risk assessment)

Ethnic Background of Origin: Caucasian - European Caucasian - Jewish (Ashkenazi) Hispanic Asian Black Other: _____

Mixed Ethnic Origin, please specify: _____

Insulin Dependent Diabetic? Yes No (Select Yes if patient was on insulin prior to this pregnancy; otherwise, select No)

Does the patient currently smoke cigarettes? Yes No

Has the patient had a previous pregnancy/child with a Neural Tube Defect? Yes No If yes, when? _____

Has the patient had a previous pregnancy/child with Down syndrome? Yes No If yes, at what age? _____

Was there an oocyte donor? Yes No If yes, what is the donor's DOB at retrieval? _____

Is this a repeat screen for the current pregnancy? Yes No

QUAD, MSAFP OR SERUM INTEGRATED SCREENING

EDD: _____ based on Ultrasound LMP Exam DATING IS UNCERTAIN (Note: Ultrasound improves screening performance)

Number of Fetuses: Singleton Twins Unknown (Risk estimates are not available for triplets)

FIRST TRIMESTER, FULL INTEGRATED OR SEQUENTIAL SCREENING

Date of Ultrasound: _____

CRL (mm) _____

NT (mm) _____

N.B. Yes No Unable to report

Name or Certification # of Sonographer _____

Note: Sonographer must be certified through either FMF or NTQR.

IF TWINS:

CRL Twin B (mm) _____

NT Twin B (mm) _____

N.B. Twin B Yes No Unable to report

Monochorionic

Dichorionic

See MLabs Test Catalog at www.mlabs.umich.edu for specimen collection and handling requirements.

<input type="checkbox"/> QUAD	(15w,0d to 22w,6d)	NT MEASUREMENT REQUIRED FOR THE FOLLOWING TESTS	<input type="checkbox"/> FTS	First Trimester Screen	(CRL 42 to 79.9 mm)
<input type="checkbox"/> MSAFP	AFP single marker – NTD only (15w,0d to 22w,6d)		<input type="checkbox"/> SS1	Sequential Screen Part 1	(CRL 36 to 79.9 mm)
<input type="checkbox"/> S11	Serum Integrated Screen Part 1 (10w,0d to 13w,6d)		<input type="checkbox"/> SS2	Sequential Screen Part 2	(15w,0d to 22w,6d)
<input type="checkbox"/> S12	Serum integrated Screen Part 2 (15w,0d to 22w,6d)		<input type="checkbox"/> FI1NT	Full Integrated Screen Part 1	(CRL 32 to 79.9 mm)
			<input type="checkbox"/> FI2NT	Full Integrated Screen Part 2	(15w,0d to 22w,6d)

Copy Distribution: White – Laboratory Yellow – MLabs SP Pink – Client

Revised: 7-11-2018 C-REFR

Specimen type for all assays: 1 mL serum, refrigerate and send within 24 hours or freeze.