QUAD/AFP REQUISITION

MLabs
Expertise Delivered Personally

Michigan Medicine – University of Michigan
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Client
REFR

Ward
REFR

Patient Reg or MRN:

Patient Name: Last First MI

Birthdate: Gender: ○M ○F

Ordering Doctor: Last First NPI#

Ordering Doctor: Phone Fax

Collected By Collection Date Collection Time ○am ○pm

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.

☐ QUAD		(15w,0d to 22w,6d)
☐ MSAFP	AFP single marker – NTD only	(15w,0d to 22w,6d)
☐ SI1	Serum Integrated Screen Part 1	(10w,0d to 13w,6d)
☐ SI2	Serum integrated Screen Part 2	(15w,0d to 22w,6d)

NT MEASUREMENT *REQUIRED* FOR THE FOLLOWING TESTS

☐ FTS	First Trimester Screen	(CRL 42 to 79.9 mm)
☐ SS1	Sequential Screen Part 1	(CRL 36 to 79.9 mm)
☐ SS2	Sequential Screen Part 2	(15w,0d to 22w,6d)
☐ FI1NT	Full Integrated Screen Part 1	(CRL 32 to 79.9 mm)
☐ FI2NT	Full Integrated Screen Part 2	(15w,0d to 22w,6d)

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

Revised: 5-16-2017 C-REFR

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