UR MEDICINE | Labs

# Specimens:			Depot:
Collect Date:	Time:	By:	ABN Signed: ☐
MR #:		A #:	

REQUIRED (PRINT OR PATIENT LABEL)

Name(Last, First, MI)

Date of Birth | Sex:(circle) M F

Street Address

Street Address 2

City, State, Zip

Phone Number | Chart Number

Indicate primary (1) and secondary (2) insurance

__ Blue Choice/Shield __ Child Health Plus __ MVP
__ Blue Choice __ Medicaid __ MVP Gold
__ Blue Choice Medicare __ Medicare __ Aetna
__ Other: _____

1. Subscriber ID: _____
Subscriber's Name: _____
Relationship to Subscriber: _____
2. Secondary Subscriber ID: _____
Subscriber's Name: _____
Relationship to Subscriber: _____

_____
_____
_____ , _____ , _____

[Address]
SEE ATTACHED REQ

Phone: Fax:

☐ (Doctor): _____

Phone Results to: Fax Results to:

Ordering Provider's Signature Date of Signature

Diagnosis Mandatory: Signs/Symptoms or ICD10 Codes
If ordered for screening, list test name here and write "SCREENING" after it

Send Additional Reports To: (Full Name/Address)

Compliance is Mandatory and Regulated. For the laboratory to bill properly and receive payment for tests ordered on Medicare Beneficiaries, specific ICD-10 code(s) or a descriptive diagnosis must be included on each patient for each test ordered.It is critical that the diagnosis provided to the lab is consistent with those recorded in the patient medical record on the date of service.

REQUIRED FIELDS FOR RESULT REPORTING:

Patient's weight _____lbs OR _____kgs
Due date (EDC) _____ Determined by: ☐ Ultrasound
☐ Last menstrual period, confirmed by ultrasound
☐ Last menstrual period. Date: _____

Additional Information (Required ultrasound information for First Trimester screen.)

Ultra sound date: _____ **ALL TESTS: Obtain NT when CRL is 43-83.9mm**
Sonographer's Name: _____ FMF or NTQR Certification #: _____
Reading MD Name: _____ FMF or NTQR Certification #: _____
CRL (mm): _____ NT (mm): _____ Twin B CRL (mm): _____ Twin B NT (mm): _____

Number of fetuses?
☐ Singleton ☐ Twins ☐ Unknown

Patient's race?
☐ Non-Black ☐ Black ☐ Unknown

Was the patient diabetic at the time of conception?
☐ No ☐ Yes

Does the patient currently smoke cigarettes?
☐ No ☐ Yes

ADDITIONAL INFORMATION:
For twins, is pregnancy monochorionic? ☐ No ☐ Yes ☐ Unknown

Is this an in vitro fertilization pregnancy?
☐ No ☐ Yes ☐ Unknown

Has the patient had a previous maternal serum screen in this pregnancy?
☐ No ☐ Yes ☐ Unknown

Has the patient taken valproic acid or carbamazepine during this pregnancy?
☐ No ☐ Yes; specify medication: _____

Has the patient had a previous pregnancy with trisomy? (i.e., Down syndrome, trisomy 18 or 13)
☐ No ☐ Yes; specify abnormality: _____

Is there a family history of neural tube defects? (i.e., spina bifida, anencephaly, encephalocele)
☐ No ☐ Yes; specify the relationship of the affected individual to the fetus: _____

SELECT THE TEST YOU INTEND TO ORDER:

MSSQA ☐ **3000143 Maternal Serum Screen Quad**
MSSAF ☐ **3000144 Maternal Serum Screen AFP**
MSSFT ☐ **3000145 Maternal Serum Screen First Trimester**

Perform blood draws when CRL is within the appropriate range:
First Trimester: CRL 43 | 83.9mm

PATIENT CONSENT

I have read the information on the back of this form and discussed it with my health care provider. My questions about Prenatal Screening have been answered. I am aware that this testing is widely accepted as a screening test for birth defects, but that it may not yet be endorsed by New York State. I authorize withdrawal and analysis of the necessary blood sample.I also authorize the UR Medicine Clinical Laboratories and the Rochester Regional Genetics Program to release my test results to my health care provider. I authorize follow up information about this pregnancy, as required by New York State, to be released confidentially to the Rochester Regional Genetics program. I agree that the serum which remains after results are completed may be used anonymously to develop techniques for prenatal diagnosis.

Patient/Legal Guardian: Date: ____ /____ /_____ Health Care Provider:

Prenatal Screening Information for Consent

1. 1ST TRIMESTER SCREENING (Must be done between 11 to 13 6/7 weeks of pregnancy)
*** Tells how high the chance is that the baby has Down syndrome or Trisomy 18***

1st Trimester Screening combines an ultrasound to measure the thickness of skin at the back of the baby's neck (the Nuchal Translucency or "NT") with a blood test to measure two substances (hCG and PAPP-A) normally found in the pregnant woman's blood. It is normal for the NT measurement to vary among healthy fetuses, and for the hCG and PAPP-A levels to vary in normal pregnancies. But if the NT measures larger than average, or the hCG or PAPP-A are high or low, the risk for chromosome problems like Down syndrome may be increased. If 1st Trimester Screening shows a high enough risk, the woman can choose an additional test like amniocentesis or chorionic villus sampling (CVS) to tell for sure if the baby is healthy. In some cases, 1st Trimester Screening may indicate that the baby's chance for a chromosome problem is low enough that a woman who was planning to have amniocentesis or CVS might choose not to have it.
1st Trimester Screening screens for:

Down Syndrome - Down syndrome is caused by an extra 21st chromosome. It results in moderate mental retardation, some physical differences and sometimes health problems such as heart defects. Children with Down syndrome have special education needs, but often these are arranged through their regular school.

Trisomy 18 - Trisomy 18 is caused by an extra 18th chromosome. It is a very severe birth defect causing many health problems and severe mental retardation. Nine out of ten babies born with Trisomy 18 do not survive beyond one year of life.

1st Trimester Screening identifies about 85% of pregnancies where the baby has Down syndrome or Trisomy 18, however in about 15% of pregnancies with these conditions, the screening result is normal. 1st Trimester Screening does not screen for Neural Tube Defects or other open fetal defects. An AFP ONLY test can be done after 14 weeks of pregnancy to screen for these.

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2. 2nd TRIMESTER AFP+ SCREENING (Also called the **"Quad Screen"** - Must be drawn after 14 and 24 6/7 weeks of pregnancy)
The recommended time for maternal serum screening is 16 to 18 weeks of pregnancy.
Tells how high the chance is for Down syndrome, Trisomy 18, or Spina bifida and other open fetal defects

AFP+ Screening is a blood test that measures the levels of four substances (AFP, Unconjugated Estriol, hCG, and Inhibin-A) in a pregnant woman's blood. It is normal for the levels of these to vary among different women, but women with particularly high or low values may be at increased risk to have a baby with certain birth defects. AFP+ Screening is usually done between 15-18 weeks of pregnancy. The AFP+ Quad Screen test screens for:

Down Syndrome - Down syndrome is caused by an extra 21st chromosome. It results in moderate mental retardation, some physical differences and sometimes health problems such as heart defects. Children with Down syndrome have special education needs, but often these are arranged through their regular school.

Trisomy 18 - Trisomy 18 is caused by an extra 18th chromosome. It is a very severe birth defect causing many health problems and severe mental retardation. Nine out of ten babies born with Trisomy 18 do not survive beyond one year of life.

Neural Tube Defects (spina bifida and anencephaly) - Neural tube defects are birth defects where the brain (anencephaly) or part of the spinal cord (spina bifida) does not form normally and may not be covered with skin or bone. Babies with anencephaly are usually stillborn or die shortly after birth. Babies with spina bifida usually have medical problems including leg paralysis, impaired bowel and bladder control, "water on the brain", and sometimes learning problems.

Abdominal Wall Defects- These birth defects are caused by an opening in the layer of muscle and skin near the "belly button". Although serious, they can often be corrected with surgery.

AFP+ Screening identifies about 75-80% of pregnancies where the baby has Down syndrome, and about 60% of pregnancies with Trisomy 18. About 90% of pregnancies with spina bifida or other open fetal defects are identified by AFP+ Screening.

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3. 2nd TRIMESTER AFP ONLY SCREENING (Must be done after 14 and 24 6/7 weeks of pregnancy)
Tells how high the chance is for Spina bifida and other open fetal defects. Does NOT screen for Down syndrome or Trisomy 18

AFP ONLY Screening is a blood test that measures the level of AFP in a woman's blood. It should be ordered only in cases where a woman has already had 1st Trimester screening or CVS, or if it is recommended after a Quad screen has shown a mild AFP elevation.

What are "Screening" Tests?

1st Trimester Screening, AFP+ Screening, and AFP ONLY are "screening" tests because they cannot tell for sure whether the fetus does or does not have a birth defect. But they can tell if there is a greater than average risk that the baby has certain birth defects. Further testing (like ultrasound or amniocentesis) can be done to tell with greater certainty if a birth defect is or is not present. About 7% of women who have a screening test will be offered further testing, and most of the time these follow up tests will show that the baby is healthy.

Please sign on the front side of this form.