PURPOSE:
To inform staff of the proper labeling, handling and transport requirements of genetics specimens (i.e. blood or amniotic fluid).

SPECIMEN AND REQUISITION LABELING
I. All specimens must be labeled with a minimum of the following:
   A. Patient’s complete first and last name
   B. Medical record number (if unknown, social security number is acceptable if available)
   C. Date and time of specimen collection
   D. Initials of the person responsible for specimen collection

II. All specimens must be accompanied by a requisition (Attachment A - First Trimester Screening Requisition, Attachment B – Multiple Marker Screening requisition) and should include:
   A. Patient’s complete first and last name
   B. Medical record number (if unknown, social security number is acceptable if available)
   C. Date of birth
   D. Physician/surgeon name legally authorized to submit specimen as well as address/phone/fax for where report is to be communicated.
   E. Pertinent medical history such as gestational age, maternal weight, diabetic status, multiple pregnancy.
   F. Date and time of collection
   G. Specification of tests being requested.
CORRECTION OF UNLABELED/MISLABELED SPECIMEN

I. Definition
   A. Mislabeled specimen – discrepancy of patient identification information between label, requisition and/or order.
   B. Unlabeled specimen – No label on the specimen.
   C. Due to the irreplaceable (critical) aspect of most genetics specimens, all attempts will be made to accurately correct labeling errors before discarding and attempting to recollect the specimen (when applicable).

II. Labeling errors identified by genetics staff:
   A. Genetics staff will identify the labeling error and contact the collector (or appropriate representative) from the office/unit to explain the error.
   B. Genetics staff will decide if specimen/requisition will be:
      i. Corrected by communication over the phone or a correction may be sent/faxed to the lab.
      ii. Corrected by office personnel who must come to the genetics lab to correct a specimen.
   C. Once the issue is corrected, the specimen will be processed accordingly.

SPECIMEN HANDLING AND TRANSPORT

I. Specimen handling
   A. All specimens should be refrigerated prior to shipment if more than a 12 hour delay between acquiring specimen and shipping/transport of specimen.
   B. The attached chart (Attachment C) details collection and handling of different specimen types.
   C. Sites should contact the pregnancy screening lab (412-641-4057) regarding questions of specimen handling and transport.

II. Specimen Packaging
   A. The primary specimen containers should be plastic and leak-resistant.
   B. Each primary container should have an individual label affixed to the outside of the container that includes the patient/collection information (detailed in section General Information: Specimen and Requisition Labeling).
Date of Initial Issue: March 2012.

Last Effective Date: N/A

Review Dates: N/A

Revision Dates: N/A

Other committee or person approval dates: N/A

Rationale:

☑ Regulatory Agency
☑ Clinical Practice
☐ Unit Operations

Responsible Person: Supervisor Pregnancy Screening Laboratory
FIRST TRIMESTER SCREENING REQUISITION

INCOMPLETE INFORMATION MAY RESULT IN DELAYED OR INACCURATE INTERPRETATION OF RESULTS. PLEASE PROVIDE ALL INFORMATION REQUESTED.

PATIENT INFORMATION (Please print)
LAST NAME ___________________________ FIRST NAME ___________________________
ADDRESS ________________________________________________________________
CITY ___________________________ STATE _________ ZIP CODE _____________
DATE OF BIRTH ______/_____/_________ SOCIAL SECURITY NUMBER _______/_____/_________
RACE __________________________________ WEIGHT (Pounds) _______________

PREGNANCY/SPECIMEN INFORMATION
Specimen Date _______/_____/______ Date of LMP _______/_____/______
Ultrasound Date _______/_____/______ Sonographer Name: __________________________
Twin Pregnancy? □ Yes □ No □ If Twins: □ Monochorionic □ Dichorionic □ Uncertain

Baby A
CRL: _______ (mm) = _______ (wk/day) CRL: _______ (mm) = _______ (wk/day)
NT: _______ (mm) NT: _______ (mm)
OB complications? □ Yes □ No □ Major maternal diseases? ____________________________

Is the patient diabetic? □ Yes □ No □ If yes, method of control? □ Insulin □ Diet □ Oral Meds __________
Assisted Reproduction? □ Yes □ No □ If donor egg, age of donor _______ yrs.
□ If frozen embryo, age at collection _______ yrs.

FAMILY HISTORY (If yes, what is the relationship to the patient?)
Spina Bifida/Amencephaly □ Yes □ No __________________________
Down syndrome □ Yes □ No __________________________
Other Birth Defects - □ Yes □ No (If Yes, Describe) __________________________

REFERRING PHYSICIAN INFORMATION
(please include a physician signature and diagnosis code if a script will not be accompanying the patient)
REFERRING PHYSICIAN (Print) __________________________ PHONE __________________________
(Signature) ______________________________________ FAX __________________________
OFFICE ADDRESS ________________________________________________________________
CITY ___________________________ STATE _________ ZIP CODE _____________

G:\PSULFS Requisition 031808.DOC
<table>
<thead>
<tr>
<th><strong>INCOMPLETE INFORMATION MAY RESULT IN DELAYED OR INACCURATE INTERPRETATION OF RESULTS. PLEASE PROVIDE ALL INFORMATION REQUESTED.</strong></th>
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<tr>
<td>DATE OF BIRTH __________ / __________ / __________ SOCIAL SECURITY NUMBER __________ / __________ / __________</td>
</tr>
<tr>
<td>MEDICAL ASSISTANCY NUMBER (if applicable) ___________________________</td>
</tr>
<tr>
<td><strong>PREGNANCY/SPECIMEN INFORMATION</strong></td>
</tr>
<tr>
<td>SPECIMEN DATE __________ / __________ / __________ □ FIRST SAMPLE □ REPEAT SAMPLE □ YES □ NO</td>
</tr>
<tr>
<td>RACE ___________________________ IS PATIENT INSULIN DEPENDENT DIABETIC? □ YES □ NO</td>
</tr>
<tr>
<td>WEIGHT (POUNDS) __________ DATE OF LMP __________ / __________</td>
</tr>
<tr>
<td>ULTRASOUND DATE __________ / __________ / __________ □ TWINS □ OTHER (____)</td>
</tr>
<tr>
<td>IF AVAILABLE __________ / __________ / __________ □ YES □ NO</td>
</tr>
<tr>
<td>□ MULTIPLE PREGNANCY? □ YES □ NO</td>
</tr>
<tr>
<td>OB COMPLICATIONS ___________________________</td>
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<td>MAJOR MATERNAL DISEASES? ___________________________</td>
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<tr>
<td>FAMILY HISTORY ___________________________ IF YES, RELATIONSHIP TO PATIENT</td>
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<td>□ YES □ NO SPINA BIFIDA/ANEURYSMAL DIA MY ___________________________</td>
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<td>□ YES □ NO DOWN SYNDROME ___________________________</td>
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<tr>
<td>□ YES □ NO OTHER BIRTH DEFECTS: IF YES, DESCRIBE ___________________________</td>
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<td>(Signature) ___________________________ DIAGNOSIS CODE ___________________________</td>
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Magee-Womens Hospital of University of Pittsburgh Medical Center

Genetics Department
Tel: (412) 641-4168 / Fax (412) 641-8730

SPECIMEN/TEST REQUEST

Multiple Marker Screening
<table>
<thead>
<tr>
<th>TEST</th>
<th>METHOD OF COLLECTION/TYPE OF COLLECTION</th>
<th>ADDITIONAL COLLECTION INSTRUCTION</th>
<th>COMMENTS</th>
<th>ASSAY TIME</th>
<th>RESULTS FORWARDED WITHIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral Blood – 1st trimester screening</td>
<td>5-8 ml in serum separator tube (SST) or red top tube.</td>
<td>Must be accompanied by completed <strong>First Trimester Screening Requisition.</strong></td>
<td>-Preferably received in lab same day. -SST (must be spun) can be sent within 7 days -Whole blood must be within 24 hours</td>
<td>48-72 hours</td>
<td>7 days</td>
</tr>
<tr>
<td>Peripheral Blood – 2nd trimester screening</td>
<td>5-8 ml in serum separator tube (SST) or red top tube.</td>
<td>Must be accompanied by completed <strong>Multiple Marker Screening Requisition.</strong></td>
<td>-Preferably received in lab same day. -SST (must be spun) can be sent within 7 days -Whole blood must be within 24 hours</td>
<td>48-72 hours</td>
<td>7 days</td>
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