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 _____ / _____ / _____

MEDICAL ASSISTANCE NUMBER (if applicable) _____

PREGNANCY/SPECIMEN INFORMATION

SPECIMEN DATE _____ / _____ / _____ ☐ FIRST SAMPLE ☐ REPEAT SAMPLE

RACE _____ IS PATIENT INSULIN DEPENDENT DIABETIC? ☐ YES ☐ NO

DID PATIENT HAVE:

CVS? ☐ YES ☐ NO

First Trimester Screen*? ☐ YES ☐ NO

*Do you want AFP only? ☐ YES ☐ NO

WEIGHT (POUNDS) _____ DATE OF LMP _____ / _____ / _____

ULTRASOUND DATE IF AVAILABLE _____ / _____ / _____ BPD (WEEKS) _____ COMPOSITE _____ NORMAL? ☐ YES ☐ NO

MULTIPLE PREGNANCY? ☐ YES ☐ NO ☐ TWINS ☐ OTHER (#) _____

OB COMPLICATIONS? _____

MAJOR MATERNAL DISEASES? _____

FAMILY HISTORY IF YES, RELATIONSHIP TO PATIENT

☐ YES ☐ NO SPINA BIFIDA/ANENCEPHALY _____

☐ YES ☐ NO DOWN SYNDROME _____

☐ YES ☐ NO OTHER BIRTH DEFECTS - 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 _____ FAX _____

(Signature) _____ DIAGNOSIS CODE _____

OFFICE ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

Magee-Womens Hospital
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Department of Genetics
Tel: (412) 641-4168 / Fax (412) 641-8730

SPECIMEN/TEST REQUEST

Multiple Marker Screening