Quest Diagnostics®

Maternal Serum Screening

BILL TO:
- ☐ My Account
- ☐ Insurance Provided
- ☐ Lab Card/Select
- ☐ Patient

PRINT PATIENT NAME (LAST, FIRST, MIDDLE)

REGISTRATION # (IF APPLICABLE) | DATE OF BIRTH M M D D YEAR | SEX

LAB REFERENCE # | CELL PHONE ( )

PATIENT ID # / MRN | PATIENT PHONE ( )

PATIENT EMAIL ADDRESS

PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT

PATIENT STREET ADDRESS (OR INSURED/RESPONSIBLE PARTY) APT. # KEY #

ACCOUNT #:

NAME:

ADDRESS:
CITY, STATE, ZIP

TELEPHONE #:

DID YOU KNOW

Reflex Tests Are Performed At An Additional Charge.

PSC Appointment Website And Telephone Number Information Listed On The Back.

Each Sample Should Be Labeled With At Least Two Patient Identifiers At Time Of Collection.

ICD Diagnosis Codes are Mandatory. Fill in the applicable fields below.

DATE COLLECTED | TIME : ☐ AM ☐ PM | TOTAL VOL/HRS. _____ ML _____ HR | ☐ Fasting ☐ Non Fasting

NPI/UPIN ORDERING/SUPERVISING PHYSICIAN AND/OR PAYERS (MUST BE INDICATED)

☐ ADDIT'L PHYS.: Dr._____ NPI/UPIN

NON-PHYSICIAN PROVIDER: | NAME | I.D.#

☐ Fax Results to: ( )_____

Send Duplicate Report to: Client # OR NAME:_____ ADDRESS:_____ CITY:_____ STATE_____ ZIP_____

PRIMARY INSURANCE

CITY | STATE | ZIP

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

PRIMARY INSURANCE CO. NAME

MEMBER / INSURED ID NO. # | GROUP #

INSURANCE ADDRESS

CITY | STATE | ZIP

ABN required for tests with these symbols

Medicare Limited Coverage Tests

@ = May not be covered for the reported diagnosis.
F = Has prescribed frequency rules for coverage.
& = A test or service performed with research/experimental kit.
B = Has both diagnosis and frequency-related coverage limitations.

Provide signed ABN when necessary

Visit QuestDiagnostics.com/MLCP for Medicare coverage guidelines

ICD Codes (enter all that apply)

Many payers (including Medicare and Medicaid) have medical necessity requirements. You should only order those tests which are medically necessary for the diagnosis and treatment of the patient.

1st TRIMESTER SCREENING ♦ # (1st Trimester Screening does not detect oNTDs) — Red Top SST - 1 Tube

16020 ☐ 1st Trimester Screen hyperGly-hCG (PAPP-A, h-hCG) (9.0-13.9 wks gestation)

@ 16145 ☐ 1st Trimester Screen, hCG (PAPP-A, hCG) (10.0-13.9 wks gestation)

INTEGRATED/SEQUENTIAL SCREENING

@ 16131 ☐ Sequential Integrated Screen ***Part 1*** (PAPP-A, hCG) **# ♦** (10.0-13.9 weeks gestation)

16148 ☐ Integrated Screen ***Part 1*** (PAPP-A) **# ♦** *(NT required)* (9.0-13.9 weeks gestation)

@ 16133 ☐ Sequential Integrated Screen ***Part 2*** (AFP, hCG, uE3, DIA) (15.0-22.9 weeks gestation)
Specimen # from Part 1 _____

@ 16150 ☐ Integrated Screen ***Part 2*** (AFP, hCG, uE3, DIA) (15.0-22.9 weeks gestation)
Specimen # from Part 1 _____

@ 16463 ☐ Stepwise Sequential Screen ***Part 1*** (PAPP-A, hCG) **# ♦** (10.0-13.9 weeks gestation)

16165 ☐ Serum Integrated Screen ***Part 1*** (PAPP-A) # (NT not required) (9.0-13.9 weeks gestation)

@ 16465 ☐ Stepwise Sequential Screen ***Part 2*** (AFP, hCG, uE3, DIA) (15.0-22.9 weeks gestation)
Specimen # from Part 1 _____

@ 16167 ☐ Serum Integrated Screen ***Part 2*** (AFP, hCG, uE3, DIA) (15.0-22.9 weeks gestation)
Specimen # from Part 1 _____

2nd TRIMESTER SCREENING # — Red Top SST - 1 Tube

@ 5059 ☐ Maternal Serum AFP (MSAFP) (15.0-22.9 weeks gestation)

@ 30294 ☐ Quad Screen (AFP, hCG, uE3, DIA) (15.0-22.9 weeks gestation)

Screens for open neural tube detects (oNTDs) only

@ 15934 ☐ Penta Screen (AFP, hCG, uE3, DIA, h-hCG)(15.0-22.9 wks gestation)

THIS INFORMATION IS REQUIRED FOR ALL TESTS ~ CALL 866-GENEINFO IF YOU HAVE ANY QUESTIONS

Date of Birth: ____/____/____ Collection Date: ____/____/____ Maternal Weight: _____ LBS

 # THIS INFORMATION IS REQUIRED FOR PART 1 OF INTEGRATED/SEQUENTIAL SCREENING, 1ST AND 2ND TRIMESTER SCREENING — Red Top SST - 1 Tube

Estimated Date of Delivery (EDD): ____/____/____ determined by: ☐ Ultrasound ☐ Last Menstrual Period (LMP) ☐ Physical Exam

Mother's Ethnic Origin: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other: _____

Number of Fetuses: ☐ One ☐ Two ☐ More than 2 How many fetuses? _____

Yes	No	
☐	☐	Patient is an insulin-dependent diabetic prior to pregnancy
☐	☐	This is a repeat specimen for this pregnancy (Repeat testing following a screen positive result for Down syndrome or Trisomy 18 is **NOT** recommended)
☐	☐	History of neural tube defect If yes explain: _____
☐	☐	Previous pregnancy with Down Syndrome
☐	☐	Pregnancy is from a donor egg Age of Donor at time of Egg Retrieval: _____
☐	☐	Patient currently smokes cigarettes

Other Relevant Clinical Information: _____

♦ THIS INFORMATION IS REQUIRED FOR 1st TRIMESTER SCREENING AND PART 1 INTEGRATED/SEQUENTIAL SCREENING.

Ultrasound date ____/____/____ Ultrasonographer's name _____

Nuchal Translucency Measurement Credentialing Agency (required, check one box)

☐ NTQR Ultrasonographer's ID# _____ Location ID # _____ Reading Physician ID# _____

☐ FMF Ultrasonographer's ID# _____ ☐ Other (List) _____ ID# _____

Crown Rump Length (CRL) _____ **mm** **Nuchal translucency (NT)** _____ **mm** Nasal Bone ☐ Present ☐ Absent ☐ Not Assessed

If twin gestation, are the twins ☐ Dichorionic ☐ Monochorionic Twin B CRL _____mm Twin B NT _____mm Twin B Nasal Bone ☐ Present ☐ Absent ☐ Not Assessed

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