In order to process your testing request, the following must be answered completely. This information is required by Quest Diagnostics to result patient testing for **StepWise 1**.

|  |  |
| --- | --- |
| PHYSICIAN NAME |   |
| PHYSICIAN PHONE |   |
| PHYSICIAN NPI |   |
| PATIENT DOB |   |
| COLLECTION DATE |   |
| MATERNAL WEIGHT |   |
| ESTIMATED DATE OF DELIVERY |   |
| **EDD DETERMINED BY** |   |
|  ULTRASOUND |   |
|  LAST MENTRUAL |   |
|  PHYSICAL EXAM |   |
| **MOTHER'S ETHNIC ORIGIN** |   |
|  AFRICAN AMERICAN |   |
|  ASIAN |   |
|  CAUCASIAN |   |
|  HISPANIC |   |
|  OTHER |   |
| NUMBER OF FETUSES |   |
| INSULIN DEPEND DIABETIC **(Y OR N)** |   |
| REPEAT SPECIMEN?  **(Y OR N)** |   |
| HISTORY OF NEURAL TUBE DEFECTS  **(Y OR N)** |   |
| BRIEF HISTORY (**attach history if applicable**) |   |
| PREVIOUS PREGNANCIES OF DOWN SYNDROME **(Y OR N)** |   |
| DONOR EGG  **(Y OR N)** |   |
| CIGARETTE SMOKER **(Y OR N)** |   |
| ULTRASOUND DATE |   |
| ULTRASONOGRAPHER'S NAME |   |
| ULTRASONOGRAPHER'S ID # |   |
| CROWN RUMP LENGTH |   |
| NUCHAL TRANSLUCENCY |   |
| **NASAL BONE** |   |
|  PRESENT |   |
|  ABSENT |   |
|  NOT ASSESSED |   |
| IF TWINS |   |
| TWIN B CROWN RUMP LENGTH |   |
| TWIN B NASAL BONE |   |
|  |   |

Please fax completed questionnaire to 219-989-3770, Attn: Reference