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 2**

|  |  |
| --- | --- |
| PHYSICIAN NAME |  |
| PHYSICIAN PHONE |  |
| PHYSICIAN NPI |  |
| PATIENT DOB |  |
| COLLECTION DATE |  |
| MATERNAL WEIGHT |  |
| ESTIMATED DATE OF DELIVERY |  |
| **MOTHER'S ETHNIC ORIGIN** |  |
| AFRICAN AMERICAN |  |
| ASIAN |  |
| CAUCASIAN |  |
| HISPANIC |  |
| OTHER |  |
| **SPECIMEN # FROM PART 1** |  |
| ULTRASOUND DATE |  |
| 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