

Maternal Serum Screening Alpha-Fetoprotein (AFP) / Request Form

		I	Place bar-coded pa	ient label here	
Dation	t Dam				
		nographics AST NAME, FIRST, MIDDLE INITIAL)		BIRTHDATE (MM/DD/YYYY)	
1 /1111.	IVI (LAC	ST NAME, PROT, MIDDLE INITIAL)		(,	
REQUES	TING PF	HYSICIAN (FULL NAME - <mark>PRINT)</mark>	PHONE	FAX*	
		F.	 FAX NUMBER MUST COMPLY WITH A	 APPLICABLE HIPAA REGULATIONS	
TI	HIS IN	FORMATION IS REQUIRED FOR ALL TESTS ~ CAL	L 866-GENEINFO IF YOU H.	AVE ANY QUESTIONS	
	S	Serum Collection date (mm/dd/yy):	Maternal Weight:L	38	
Estimat	ed Date		l Ultrasound □ Last Menstrual P	eriod (LMP) 🗖 Physical Exam	
Mother's Ethic Origin: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other:					
Number of Fetuses:					
Clinical History					
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 a donor egg Age of Donor at t	time of Egg Retrieval:		
		Patient currently smokes cigarettes			
Other	Relevar	nt Clinical Information:			
	-	Uncluding Medicare and Medicaid have medical necessity requessary for the diagnosis and treatment of the patient.	uirements. Only order those tests t	vhich are considered	
General Information					
	stimate	g information must be provided in order to produce the model and the sed date of delivery, and weight. By providing all required			

If you have any questions, call 866-GENEINFO.