NORTH MISSISSIPPI MEDICAL CENTER

Complete, print and submit.

Reset Form

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

Place bar-coded patient label here

Patient Demographics

PATIENT *(LAST NAME, FIRST, MIDDLE INITIAL)*		*BIRTHDATE (MM/DD/YYYY)*
REQUESTING PHYSICIAN (FULL NAME - PRINT)	PHONE	FAX*

FAX NUMBER MUST COMPLY WITH APPLICABLE HIPAA REGULATIONS

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

Serum Collection date (mm/dd/yy): _____ Maternal Weight: _____LBS

THIS INFORMATION IS REQUIRED FOR PART 1 OF INTEGRATED/SEQUENTIAL SCREENING, 1ST AND 2ND TRIMESTER SCREENING(1 Red Top SST)

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

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

Number of Fetuses: ☐ One ☐ Two ☐ More than 2 How many 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 time of Egg Retrieval: _____
☐	☐	Patient currently smokes cigarettes

Other Relevant Clinical Information:

_____

Many payers \including Medicare and Medicaid\ have medical necessity requirements. Only order those tests which are considered medically necessary for the diagnosis and treatment of the patient.

General Information

The following information must be provided in order to produce the most accurate report: Serum Collection Date, Date of Birth, estimated date of delivery, and weight. **By providing all required information, the most accurate patient risk can be calculated.**

If you have any questions, call 866-GENEINFO.

Form to be used for AFP AOE information

Print

created 1/18/2019