Legacy Laboratory Services
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PRENATAL SCREENING REQUISITION

NOTICE: **Patients are responsible to use a lab that is contracted with their insurance company.**

CLINIC NAME: ______________________________
PROVIDER NAME: ______________________________
ADDRESS: ______________________________
PHONE #: ______________________________

PATIENT'S LEGAL NAME (LAST, FIRST, MI) (REQUIRED)		PATIENT'S SOCIAL SECURITY # (LAST FOUR ONLY):
DATE OF BIRTH (REQUIRED)	SEX ☐ MALE ☐ FEMALE	COLLECTION DATE: ______________
PATIENT'S HOME ADDRESS (REQUIRED)		DX CODE: ________ ________ ________

IMPORTANT: *Specimens cannot be run outside the approved gestational age.*

- ☐ **1ST TRIMESTER SCREEN (11 weeks, 0 days to 13 weeks, 6 days)** ROE: MS FTP
- ☐ **QUAD, 2ND TRIMESTER SERUM SCREEN (15 weeks, 0 days to 20 weeks, 6 days)** ROE: MS QUAD
- ☐ **AFP, 2ND TRIMESTER SERUM SCREEN (15 weeks, 0 days to 20 weeks, 6 days)** ROE: MS AFP
- ☐ **AFP, 2ND TRIMESTER AMNIOTIC FLUID SCREEN (15 weeks, 0 days to 22 weeks, 6 days)** ROE: AFAFP

REQUIRED INFORMATION

All information is required for correct interpretation for all screens.

Mother's ethnicity? ☐ Asian ☐ Black ☐ Caucasian ☐ Other
Mother's weight (lbs)? ______________ lbs
Estimated Date of Delivery (EDD)? ______________ (mm/dd/yyyy)
EDD determined by? ☐ Last Menstrual Period (LMP) ☐ Ultrasound
NOTE: Ultrasound provides the most reliable gestational age.
Number of fetuses (current pregnancy)? ☐ 1 ☐ 2 ☐ >2
If fetus # is > 1, chorion? ☐ Dichorionic ☐ Monochorionic
Repeat test during same pregnancy? ☐ No ☐ Yes
NOTE: Check Yes if same test was ordered during this pregnancy.
Medication dependent diabetic at conception? ☐ No ☐ Yes ☐ Unknown
Did patient smoke at the time of conception? ☐ No ☐ Yes ☐ Unknown
Pregnancy due to In-Vitro Fertilization (IVF)? ☐ No ☐ Yes
NOTE: The age of egg affects the risk calculations.
If egg donor (other than patient), need the Donor DOB (mm/dd/yyyy): ______________ **or current age (years):** ________.
Previous pregnancy with chromosome abnormality?
- ☐ No
- ☐ T21 (Down)
- ☐ T18
- ☐ T13
- ☐ Other – Specify: __________

ADDITIONAL INFORMATION REQUIRED FOR SECOND TRIMESTER SCREEN

Has mother had a previous pregnancy with Neural Tube Defects (NTD)? ☐ No ☐ Yes ☐ Unknown
Does either parent have a NTD? ☐ No ☐ Yes ☐ Unknown
Does any grandparent have a NTD? ☐ No ☐ Yes ☐ Unknown

ADDITIONAL INFORMATION REQUIRED FOR FIRST TRIMESTER SCREEN

Ultrasound date ______________ (mm/dd/yyyy)
Sonographer name ______________________ (Last, First)
Sonographer Certification # ______________
Nuchal Translucency (NT) in mm ________ mm (0.1-4.0 mm) Twin: ________ mm (if applicable)
Crown Rump Length (CRL) in mm ________ mm (40.6-84.0 mm) Twin: ________ mm (if applicable)

PER CLIA REGULATIONS, AN AUTHORIZED SIGNATURE IS REQUIRED FOR ALL FAXED LAB ORDERS

AUTHORIZED SIGNATURE: ______________________________ **DATE:** __________

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