



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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
PATIENT'S HOME ADDRESS (REQUIRED)	COLLECTION DATE: _____
	DX CODE: _____

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

<input type="checkbox"/> 1 ST TRIMESTER SCREEN (11 weeks, 0 days to 13 weeks, 6 days)	ROE: MS FTP
<input type="checkbox"/> QUAD, 2 ND TRIMESTER SERUM SCREEN (15 weeks, 0 days to 20 weeks, 6 days)	ROE: MS QUAD
<input type="checkbox"/> AFP, 2 ND TRIMESTER SERUM SCREEN (15 weeks, 0 days to 20 weeks, 6 days)	ROE: MS AFP
<input type="checkbox"/> AFP, 2 ND 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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Please Note: If you do not have a plain paper FAX, any laboratory report included in this transmittal must be copied onto plain paper to be maintained as a permanent medical record. Thank you.