Legacy Laboratory Services
1225 NE 2nd Ave
Portland, Or 97232
Ph: 503-413-1234
Fx: 503-413-5048
Ph: 1-877-270-5566
Fx: 1-800-494-0252

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:** _____