Quest Diagnostics®

Maternal Serum Screening New York

BILL TO:
- ☐ My Account
- ☐ Insurance Provided
- ☐ Lab Card/Select
- ☐ Patient

PRINT PATIENT NAME (LAST, FIRST, MIDDLE)

REGISTRATION # (IF APPLICABLE) | DATE OF BIRTH M M D D YEAR | SEX

LAB REFERENCE # | CELL PHONE ( )

PATIENT ID # / MRN | **PATIENT PHONE** ( )

PATIENT EMAIL ADDRESS

PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT

PATIENT STREET ADDRESS (OR INSURED/RESPONSIBLE PARTY) APT. # KEY #

DID YOU KNOW

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PSC Appointment Website And Telephone Number Information Listed On The Back.

Each Sample Should Be Labeled With At Least Two Patient Identifiers At Time Of Collection.

ICD Diagnosis Codes are Mandatory. Fill in the applicable fields below.

ACCOUNT #:

NAME:

ADDRESS:
CITY, STATE, ZIP

TELEPHONE #:

DATE COLLECTED | TIME : ☐ AM ☐ PM | TOTAL VOL/HRS. _____ ML _____ HR | ☐ Fasting ☐ Non Fasting

NPI/UPIN ORDERING/SUPERVISING PHYSICIAN AND/OR PAYERS (MUST BE INDICATED)

☐ ADDIT'L PHYS.: Dr._____ NPI/UPIN

NON-PHYSICIAN PROVIDER: | NAME | I.D.#

☐ Fax Results to: ( )_____

Send Duplicate Report to: Client # OR NAME:_____
ADDRESS:_____
CITY:_____ STATE_____ ZIP_____

PRIMARY INSURANCE

CITY | STATE | ZIP

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

PRIMARY INSURANCE CO. NAME

MEMBER / INSURED ID NO. # | GROUP #

INSURANCE ADDRESS

CITY | STATE | ZIP

ABN required for tests with these symbols

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@ = May not be covered for the reported diagnosis.
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Provide signed ABN when necessary

Visit QuestDiagnostics.com/MLCP for Medicare coverage guidelines

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Many payers (including Medicare and Medicaid) have medical necessity requirements. You should only order those tests which are medically necessary for the diagnosis and treatment of the patient.

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FOLD HERE

1st TRIMESTER SCREENING ♦ # (1st Trimester Screening does not detect oNTDs) — SST Tube

& 16969 ☐ 1st Trimester Screen hyperGly-hCG (PAPP-A, h-hCG) (9.0-13.9 wks gestation)

& 16968 ☐ 1st Trimester Screen, hCG (PAPP-A, hCG) (10.0-13.9 wks gestation)

INTEGRATED/SEQUENTIAL SCREENING

& 16974 ☐ Sequential Integrated Screen ***Part 1*** (PAPP-A, hCG) #♦ (10.0-13.9 weeks gestation)

& 16976 ☐ Integrated Screen ***Part 1*** (PAPP-A) #♦ *(NT required)* (9.0-13.9 weeks gestation)

16975 ☐ Sequential Integrated Screen ***Part 2*** (AFP, hCG, uE3, DIA) (14.0-22.9 weeks gestation)
Specimen # from Part 1 _____

16977 ☐ Integrated Screen ***Part 2*** (AFP, hCG, uE3, DIA) (14.0-22.9 weeks gestation)
Specimen # from Part 1 _____

& 16464 ☐ Stepwise Sequential Screen ***Part 1*** (PAPP-A, hCG) #♦ (10.0-13.9 weeks gestation)

& 16973 ☐ Serum Integrated Screen ***Part 1*** (PAPP-A) # (NT not required) (9.0-13.9 weeks gestation)

16466 ☐ Stepwise Sequential Screen ***Part 2*** (AFP, hCG, uE3, DIA) (14.0-22.9 weeks gestation)
Specimen # from Part 1 _____

16966 ☐ Serum Integrated Screen ***Part 2*** (AFP, hCG, uE3, DIA) (14.0-22.9 weeks gestation)
Specimen # from Part 1 _____

2nd TRIMESTER SCREENING # — SST Tube

@ 92788 ☐ Maternal Serum AFP (MSAFP) (15.0-22.9 weeks gestation)

16333 ☐ Quad Screen (AFP, hCG, uE3, DIA) (14.0-22.9 weeks gestation)

Screens for open neural tube detects (oNTDs) only

16970 ☐ Penta Screen (AFP, hCG, uE3, DIA, h-hCG)(15.0-22.9 wks gestation)

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

Date of Birth: ____/____/____ Collection Date: ____/____/____ Maternal Weight: _____ LBS

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

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

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

Number of Fetuses: ☐ One ☐ Two ☐ More than 2 How many fetuses? _____

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 donor egg Age of Donor at time of Egg Retrieval: _____
☐	☐	Patient currently smokes cigarettes

Other Relevant Clinical Information: _____

♦ THIS INFORMATION IS REQUIRED FOR 1st TRIMESTER SCREENING AND PART 1 INTEGRATED/SEQUENTIAL SCREENING.

Ultrasound date ____/____/____ Ultrasonographer's name _____

Nuchal Translucency Measurement Credentialing Agency (required, check one box)

☐ NTQR Ultrasonographer's ID# _____ Location ID # _____ Reading Physician ID# _____

☐ FMF Ultrasonographer's ID# _____ ☐ Other (List) _____ ID# _____

Crown Rump Length (CRL) _____ **mm** **Nuchal translucency (NT)** _____**mm** Nasal Bone ☐ Present ☐ Absent ☐ Not Assessed

If twin gestation, are the twins ☐ Dichorionic ☐ Monochorionic Twin B CRL _____mm Twin B NT _____mm Twin B Nasal Bone ☐ Present ☐ Absent ☐ Not Assessed

INFORMED CONSENT MATERNAL SERUM SCREENING

1. Integrated/Sequential Screening (Integrated Screen, Sequential Integrated Screen and Serum Integrated Screen) is offered to screen for certain chromosome disorders, such as Down syndrome and trisomy 18. Integrated Screen may lead to the detection of 94-96% of fetuses with Down syndrome and 90% of fetuses with trisomy 18. Sequential Integrated Screen may lead to the detection of 95% of fetuses with Down syndrome and 90% of fetuses with trisomy 18. Serum Integrated Screen may lead to the detection of 85-88% of fetuses with Down syndrome and 90% of fetuses with trisomy 18. Integrated/Sequential Screening are also offered to screen for open neural tube defects and may lead to the detection of 95% of fetuses with anencephaly and 65-80% of fetuses with open spina bifida. Thus, Integrated/Sequential Screening will not lead to the detection of all fetuses with open neural tube defects, Down syndrome or trisomy 18.

   First Trimester Maternal Serum Screening (1st Trimester Screen with hyperGly-hCG and 1st Trimester Screen with hCG) is offered to screen for certain chromosome disorders, such as Down syndrome and trisomy 18. 1st Trimester Screen with hyperGly-hCG may lead to the detection of 83% of fetuses with Down syndrome and 75% of fetuses with trisomy 18. 1st Trimester Screen with hCG may lead to the detection of 82-87% of fetuses with Down syndrome and 75% of fetuses with trisomy 18. Thus, First Trimester Maternal Serum Screening will not lead to the detection of all fetuses with Down syndrome or trisomy 18. Also, First Trimester Maternal Serum Screening will not lead to the detection of open neural tube defects.

   Second Trimester Maternal Serum Screening (MSAFP, Triple Screen, Quad Screen and Penta Screen) is offered to screen for open neural tube defects and may lead to the detection of 95% of fetuses with anencephaly and 65-80% of fetuses with open spina bifida. Triple Screen, Quad Screen and Penta Screen are offered to screen for certain chromosome disorders, such as Down syndrome and trisomy 18. Triple Screen may lead to the detection of 69% of fetuses with Down syndrome and 73% of fetuses with trisomy 18. Quad Screen may lead to the detection of 81% of fetuses with Down syndrome and 73% of fetuses with trisomy 18. Penta Screen may lead to the detection of 83% of fetuses with Down syndrome and 73% of fetuses with trisomy 18. Thus, Second Trimester Maternal Serum Screening will not lead to the detection of all fetuses with open neural tube defects, Down syndrome or trisomy 18. Also, MSAFP will not lead to the detection of Down syndrome or trisomy 18.
2. Neural tube defects (such as spina bifida and anencephaly) occur when the spine and brain do not develop completely. Down syndrome and trisomy 18 result from the presence of an extra chromosome (numbers 21 and 18, respectively) and cause both mental and physical abnormalities.
3. Some open neural tube defects and those covered with skin may not be detected. Most other birth defects and mental retardation are NOT detectable by Maternal Serum Screening.
4. Screen positive results mean further testing may be necessary to determine if the fetus has a neural tube defect, Down syndrome or trisomy 18. Such testing may include a repeat Maternal Serum Screen test, ultrasound, removal and testing of a small amount of chorionic villi (CVS), or removal and testing of a small amount of amniotic fluid (amniocentesis).
5. Screen positive results may occur for reasons such as: miscalculation of due date, twin pregnancy, vaginal bleeding, or the presence of other rare birth defects. Sometimes the results are screen positive for no apparent reason.
6. At the request of your physician, screen positive results will be given to a diagnostic center for follow-up.

I certify that I have read the above consent and understand its content, including the BENEFITS and LIMITATIONS of Maternal Serum Screening and request that it be performed. I have discussed the test with my physician.

Patient Signature (required for New York residents only)	Date	Physician Signature (required for New York residents only)	Date

Patients: Minimize your wait time by scheduling an appointment at a convenient Patient Service Center.

To find a location and make an appointment visit us at QuestDiagnostics.com/appointment or call 888-277-8772 or simply download our mobile app. at QuestDiagnostics.com/mobile

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