



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 #

ACCOUNT #:

NAME:

ADDRESS:
CITY, STATE, ZIP

TELEPHONE #:

DID YOU KNOW**Reflex Tests Are Performed At An Additional Charge.****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.**DATE COLLECTED TIME AM PM TOTAL VOL/HRS. Fasting Non Fasting
: ML HR

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 Client # OR NAME:

Duplicate ADDRESS:

Report to: 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**Medicare Limited Coverage Tests**

@ = May not be covered for the reported diagnosis.
 F = Has prescribed frequency rules for coverage.
 & = A test or service performed with research/experimental kit.
 B = Has both diagnosis and frequency-related coverage limitations.

Provide signed ABN when necessary**Visit QuestDiagnostics.com/MLCP for Medicare coverage guidelines****ICD Codes (enter all that apply)**

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.

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 116977 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 116966 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 defects (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 ExamMother'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 AssessedIf twin gestation, are the twins Dichorionic Monochorionic Twin B CRL _____ mm Twin B NT _____ mm Twin B Nasal Bone Present Absent Not Assessed**Provide signed ABN when necessary****Provide signed ABN when necessary****Provide signed ABN when necessary****ICD Diagnosis Codes are Mandatory. Fill in the applicable fields below.****Provide signed ABN when necessary****Provide signed ABN when necessary**

SMOOTHSEAL®

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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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REGISTRATION # (IF APPLICABLE)

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 This is a repeat specimen for this pregnancy (Repeat testing following a screen positive result for Down syndrome or Trisomy 18 is **NOT** recommended)
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