Indiana University Health

IU Health System Pathology Laboratories
350 W. 11th Street, Room 5013
Indianapolis, IN 46202-4108
317.491.6000 or 800.433.0740
Fax: 317.491.6001

1) Patient Legal Name (Last, First MI)		DOB	2) ( ) STAT	Date/Time of Collection
Patient Social Security #	Race	MR#/Alternate Pt ID		Phone Results To:
Patient Address		Phone		Fax Results To:
City, State, Zip		M F	4) **BILL PATIENT/INSURANCE COMPANY**	
3) Physicians Signature	Order Date	Print Physicians Name (F,MI,L)	ATTACH A COPY OF FACE SHEET AND INSURANCE CARD - ALL required (highlighted) fields must be complete to bill patient's insurance company. Specimen will be registered as patient self-pay and bill will be the responsibility of the patient if required information is not provided.	

Client (Clinic/Physician) Information	Group Physicians	Primary Insurance
		Company Name:
		IU/Policy# Group #/Name:
		Insurance Co. Address:
Send Additional Report To:		City: State/Zip:
		Policy Holder Name:
		Relationship to Patient:

Notice: Medicare will only pay for tests that meet the Medicare definition of "Medical Necessity". Medicare may deny payment for a test that the physician believes is appropriate, such as a screening test. If a test is being ordered as a screen, be certain the patient has signed the Advanced Beneficiary Notice (ABN) located on back of this requisition.	5) ICD Diagnosis Codes (Enter ALL that apply)		1	2	3
	4	5	6	7	8

Genetic Counselor:	Phone:	Fax:

Maternal Serum Testing

Specimen:
☐ Serum Draw Date:_____/_____/_____ Date Sent:_____/_____/_____

Select Test:
7050 ☐ **MS AFP Screen** *3948* ☐ **Quad Marker Screen** Draw between gestation (15 wks., 0 days - 21 wks., 6 days gestation)

315 ☐ **First Screen** 10.4-13.9 wks. (*1st Scrn*) 302 ☐ **Integrated Screen/Serum Integrated** 10.4-13.9 wks. (*IntgScn1*) 335 ☐ **Sequential Screen** 10.4-13.9 wks. (*SeqScrn*)

Ethnicity: ☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Ashkenazi Jewish ☐ Sephardic Jewish ☐ Native American ☐ Other_____

Other Required Information:

Gravida:_____ Para:_____ SAB:_____ TAB:_____
U/S Date:_____/_____/_____ GA on U/S Date:_____ Wks _____ Days _____
Sonographer Name: _____ NTQR ID# _____
Reading MD BTQR ID# _____ Practice Location ID# _____
NT: _____mm CRL:_____mm
NT: _____mm CRL:_____mm (Twin, if applicable)

LMP Date:_____/_____/_____ EDC Date:_____/_____/_____ by ☐ U/S ☐ LMP ☐ PE
IVF Fertilization Date:___/___/___ IVF Egg donor Age (if applicable):_____
Maternal Weight_____lbs. # Fetuses:_____ ☐ Repeat Screen
Y N Does patient currently smoke?
Y N Insulin-dependent diabetic prior to pregnancy (insulin OR oral hypoglycemics)
Y N Previous Down syndrome pregnancy/child
Y N Family history of NTD, specify:_____

Client contact information for notification of abnormal results:
Name_____ Phone_____ Pager_____
I attest that this patient has been informed about and has given consent for the test(s) I have ordered.
_____*Physician/Designee Signature*

ATTENTION
IUHPL Specimen Processing – forward ALL paperwork or requisitions for 302, 315, or 335 to Send Outs Room 5001A

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City, State, Zip		M F	4) **BILL FACILITY / CLIENT**	
3) Physicians Signature	Order Date	Print Physicians Name (F, MI, L)	( ) Split Bill: TC to Facility & PC to Insurance (Medicare, Medicaid) **Attention PFN**: do not register, send patient directly back to lab	
Client (Clinic/Physician) Information			Group Physicians	
Send Additional Report To:				

Genetic Counselor:	Phone:	Fax:

Maternal Serum Testing

Specimen:
☐ Serum Draw Date:_____/_____/_____ Date Sent:_____/_____/_____

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