Dartmouth Hitchcock Requisition for FIRST or SECOND TRIMESTER SAMPLES for Prenatal Screening

Information relative to these testing services may be requested from or released to third parties for the purposes of clinical assessment or to process claims for payment of benefits.

Women & Infants Hospital
A Care New England Hospital
70 Elm Street, 2nd floor
Providence, Rhode Island 02903
(401) 453-7650 FAX (401) 276-7882

PATIENT NAME: LAST, FIRST MIDDLE

BILLING ADDRESS (STREET No. or P.O. BOX)

CITY STATE ZIP CODE

DH Affix Label Here

DATE OF BIRTH | SAMPLE DRAW DATE

1st SAMPLE REFERRING PROVIDER | REFERRING PROVIDER PHONE #

2nd SAMPLE REFERRING PROVIDER | FAX #

PATIENT MEDICAL RECORD

FOR PATIENT OR INSURANCE BILLING — COMPLETE THE INFORMATION BELOW

CHECK TEST(S) REQUESTED

First Trimester (11w,0d - 13w,6d ga)

- ☐ **INTEGRATED SCREEN Part 1** (PAPP-A component)
  Full Integrated requires 1st trimester NT measurements
  Serum Integrated needs only the 1st trimester sample
- ☐ **SEQUENTIAL SCREEN Part 1** (PAPP-A component)
  requires nuchal translucency (NT) measurements
- ☐ **FIRST TRIMESTER SCREEN** (PAPP-A, hCG,
  requires nuchal translucency (NT) measurements

Second Trimester (15 w0d– 22w6d)

- ☐ **INTEGRATED SCREEN Part 2** (AFP, Estriol, hCG, Inhibin plus an ultrasound dated 1st trimester PAPP-A component)
- ☐ **SEQUENTIAL SCREEN Part 2** (AFP, Estriol, hCG, Inhibin plus an ultrasound dated 1st trimester PAPP-A component)
- ☐ **Quad Screen** (AFP, Estriol, hCG, Inhibin)
- ☐ **AFP ONLY– for NTD screening only**

PART A Dating information is required for interpretation of results

LMP date: ____/____/____ U/S date: ____/____/____ GA on U/S date: _____ wks, _____ days ☐ Check box if by BPD.

NT U/S date: ____/____/____ NT: _____ mm CRL: _____ mm | Sonographer name: _____ Site where U/S done_____

If twin pregnancy: twin B NT: _____ mm twin B CRL: _____ mm Chorionicity: ☐ Mono ☐ Di ☐ Unknown

PART B Patient background is required for proper risk assessment

Height: _____ Weight (lbs.): _____

Race/Ethnicity: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Other

Pregnancy History: Vaginal bleeding this pregnancy? Y N

Cigarette smoker? If yes, how many per day? _____ Y N

Has the patient already had...

☐ Amniocentesis? or ☐ CVS? date ____/____/____

☐ First trimester test for Down syndrome? date ____/____/____

Reason for screening...

Advanced maternal age
- ☐ Primagravida
- ☐ Multigravida

- ☐ Routine screening
- ☐ Family hx: NTD, DS, or T18
- ☐ Previous pregnancy w/ DS or T18
- ☐ Other: _____

Insulin dependent diabetic prior to this pregnancy? Y N

Multiple pregnancy? If yes, number of fetuses: _____ Y N

Fetal demise this pregnancy? If yes, explain (comments) Y N

IVF this pregnancy? If egg donor, age of donor___ Y N

Previous pregnancy diagnosed to have Down syndrome? Y N

Family history: Spina bifida, Anencephaly, or Hydrocephaly? Y N
If yes, describe:

COMMENTS