

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

FBR FOUNDATION FOR BLOOD RESEARCH

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PLEASE CHECK: BILL SENDER BILL PATIENT BILL INSURANCE
If insurance information or patient address are not provided, charges will be submitted to Sender

BEST RESULTS IF BLOOD DRAWN BETWEEN _____ / _____ / _____ AND _____ / _____ / _____

PATIENT NAME: LAST, FIRST MIDDLE	
BILLING ADDRESS (STREET No. or P.O. BOX)	
CITY	STATE ZIPCODE
DATE OF BIRTH	SAMPLE DRAW DATE
1 st SAMPLE REFERRING PROVIDER	OFFICE TEL #
2 nd SAMPLE REFERRING PROVIDER	OFFICE TEL #
PATIENT ID ACCOUNT CODE	

SENDER: (Hospital or Laboratory name & address)	FOR FBR USE ONLY
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FOR PATIENT OR INSURANCE BILLING --- COMPLETE THE INFORMATION BELOW

SUBSCRIBER
INS. CO. NAME
ID CERT. NO
GROUP NO
STATE

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.

CHECK TEST(S) REQUESTED

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

INTEGRATED SCREEN Part 1 (PAPP-A component)
Full Integrated requires 1st trimester NT measurement
Serum Integrated needs only the 1st trimester sample

SEQUENTIAL SCREEN Part 1 (PAPP-A component)
requires nuchal translucency (NT) measurement

FIRST TRIMESTER SCREEN (PAPP-A, hCG, Inhibin)
requires nuchal translucency (NT) measurement

Unless this box is checked, any remaining sample and clinical information may be used to develop future laboratory tests.

Second Trimester (15-21 wks ga)

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)

AFP PROFILE FOUR (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

Sonographer Site where
NT U/S date: ____ / ____ / ____ NT: ____ mm CRL: ____ mm name: _____ 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: <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Other
Pregnancy History: Vaginal bleeding this pregnancy? Y N	Insulin dependent diabetic prior to this pregnancy? Y N
Cigarette smoker? Y N If yes, how many per day? _____	Multiple pregnancy? Y N If yes, number of fetuses: _____
Has the patient already had...	Fetal demise this pregnancy? Y N If yes, comment below:
<input type="checkbox"/> Amniocentesis? or <input type="checkbox"/> CVS? date ____ / ____ / ____	IVF this pregnancy? Y N If donor egg, age of donor: _____
<input type="checkbox"/> First trimester test for Down syndrome? date ____ / ____ / ____	Previous pregnancy diagnosed to have Down syndrome? Y N
Reason for screening...	NTD Family history: (Spina bifida or Anencephaly)? Y N
<input type="checkbox"/> Routine screening	If yes, describe:
Advanced maternal age <input type="checkbox"/> Family hx: NTD, DS, or T18	COMMENTS
<input type="checkbox"/> Primigravida <input type="checkbox"/> Previous pregnancy w/ DS or T18	
<input type="checkbox"/> Multigravida <input type="checkbox"/> Other: _____	