



Marshfield Labs™

A division of Marshfield Clinic

PATIENT NAME		COLLECTION DATE
DOB	REQUESTING DR.	COLLECTION TIME
MHN	ROUTING LOCATION	COMPLETED BY

Maternal Serum Screen Request

TO ORDER:

- Complete the upper portion of this form with the following required information: patient's full name, DOB, medical history number, location, date and time of specimen collection, the requesting provider's name or number and your initials.
- Check the box immediately preceding the desired test below.

- Provide the appropriate ICD diagnosis code (specific reason why this test was ordered) in the space after the ordered test. Use individual order sheets as a reference.
- Complete the entire Clinical Information section.

IF MEDICARE PATIENT:

- If the diagnosis for a test is not on the Medicare "approved" list (see individual test order sheets), the patient must sign and receive a copy of the waiver. The waiver notifies the patient that Medicare is likely to deny coverage.

Test Order

AFP-1 (Single marker MSS) ICD _____
 Second trimester maternal serum screen (MSS) for open spina bifida only (between 15 wks, 0 day and 21 wks, 6 days).
Not intended for Down syndrome screening.

Clinical Information

Current Pregnancy Information

Has the patient had a first trimester screen:
 Yes No

If yes, order AFP-1 (Single marker MSS)

Expected delivery date (EDD) (mm/dd/yy)
 ____ / ____ / ____

EDD is based on: L.M.P. Ultrasound

In-vitro fertilization (IVF): Yes No

If yes, donor's date of birth (if not the patient)
 (mm/dd/yy) ____ / ____ / ____

Maternal weight in lbs. _____

Maternal race/ethnicity:

- Caucasian/White
 African American/Black
 Other

Is the patient an insulin-dependent diabetic: Yes No

Is the patient a smoker: Yes No

Multiple gestation: Yes No

If yes, specify _____

Previous Pregnancy History

Previous child, or parent of fetus has Down syndrome:

- Yes No

Family history of neural tube defect:

- No
 1st degree (sibling or parent of fetus)
 2nd degree (uncle, aunt, grandparent of fetus)
 3rd degree (cousin of fetus)
 Other (or unknown)

If other, specify _____