

PT. NO.

NAME (Last, First)

D.O.B.

M

F

CLINICAL LAB REQUEST
 UW MEDICINE
 LABORATORY MEDICINE COMMUNITY SERVICES
 CLINICAL IMMUNOLOGY LAB: 206-598-6149

UW LAB ACC. #

LOGGED IN BY: _____ PROCESSED BY: _____

Prenatal Risk

1. Completely fill in left section.
2. Additional information (*) can be found on the **back page**.
3. Please make a copy of requisition for Immunology Lab.

NOTE: When ordering tests for which Medicare reimbursement will be sought, physicians should only order tests which are medically necessary for diagnosis or treatment of the patient. You should be aware that Medicare generally does not cover routine screening tests, and will only pay for tests that are covered by the program and are reasonable and necessary to treat or diagnose the patient.

ORDERING PHYSICIAN / PHONE # **REQUIRED** UPIN # **REQUIRED**

SPECIMEN TYPE Serum, Freeze @ -20°C Amniotic Fluid, Refrigerate

DATE & TIME COLLECTED AM PM **REQUIRED**

SENDER SPECIMEN #

UW HOSPITAL #

ICD9 (diagnosis) code **REQUIRED**
 See code box on right side of form

SEND REPORT TO (Hospital, Clinic, Physician)

ADDRESS

PATIENT ADDRESS

CITY STATE ZIP

TELEPHONE

SUBSCRIBER NAME

SUBSCRIBER ID. #

GROUP# SS#

Premera Blue Cross Regence DSHS (attach coupon)

Medicare (answer required to question below)
 Is this either a hospital outpatient or inpatient?
 Yes No
 (see reverse for additional information)

OTHER INSURANCE NAME/ADDRESS

SERUM SPECIMENS **AMNIOTIC FLUID**

This section required for all Prenatal Tests EXCEPT Integrated 2nd Trimester (PRINT2)

Previous child with Down Syndrome? Y N
 If yes, explain _____
 Maternal Age at previous DS birth: _____
 Previous child with Neural Tube Defect? Y N
 If yes, explain _____
 Insulin dependent diabetic prior to pregnancy? Y N
 IVF Pregnancy? Y N
 If donor egg, age of donor _____ at EDD
 Maternal weight: _____ lbs. **Is this test a repeat?** Y N
 # of Fetuses: 1 2
 Race: Black Non-Black
Provide Gestational Age (US preferred) *:
 Gest. Age on blood draw date: _____ wks, _____ days
 _____ US date: _____ Gest. Age _____ wks, _____ days
 _____ LMP date: _____

AMNIOTIC FLUID AFP AAFPX
 (15 wks, 0 days - 22 wks, 0 days)
 Includes ACHE and Blood Contamination studies if AFP is positive.

US date: _____
 MONTH / DAY / YEAR
 Gest. Age on US date: _____ wks, _____ days

Make a copy for Imm.

MEDICAL NECESSITY DOCUMENTATION, REQUIRED FOR OUTPATIENT TESTING

ICD9 CODE (Preferred) or DIAGNOSIS / SIGNS & SYMPTOMS

659.53 Elderly Primigravida
 659.63 Elderly Multigravd
 655.03 Fetal CNS Malform
 655.13 Chromosome Abnormality
 655.93 Fetal Abnormality NOS
 V22.0 Normal 1st Pregnancy
 V22.1 Normal 2nd or > Pregnancy
 V28.89 Antenatal Screening, other
 _____ Enter other code

Immunology Lab will call all POSITIVE Results:

Phone # _____
 Pager # _____
 Fax # _____

Please provide physician's contact numbers

The following 2 tests require CRL and NT information **AND** the information above.

INTEGRATED PRENATAL SCREEN 1st TRI. * PRINT1
 (NT plus serum preferred, serum only is acceptable)
 (11 wks, 0 days - 13wks, 6 days)
 Includes: NT, PAPP-A

FIRST TRIMESTER ONLY * PR1ST
 (11 wks, 0 days - 13 wks, 6 days)
 Includes: NT, hCG and PAPP-A

Was NT measurement done? Y N
If No, provide Gestational age above.

Ultrasound Date: _____

CRL: _____ mm (45-84 mm acceptable), **NT:** _____ mm
 If twins: **CRL:** _____ mm, **NT:** _____ mm

Sonographer: _____ Cert. Code: _____ **REQUIRED**
 (Information **MUST** accompany NT for NT to be used in calculation)

INTEGRATED PRENATAL SCREEN 2nd TRI. PRINT2
 Only run if Integrated 1st Trimester sample sent
 Pregnancy information **NOT** needed for 2nd trimester
 (15 wks, 0 days - 22 wks, 0 days)
 Includes: AFP, hCG, Estriol, Inhibin

QUAD SCREEN, 2nd TRIMESTER ONLY PRQUAD
 (15 wks, 0 days - 22 wks, 0 days)
 Includes: AFP, hCG, Estriol, Inhibin

AFP, 2nd TRIMESTER ONLY PRMAFP
 (15 wks, 0 days - 22 wks, 0 days)

Other Requests/ Comments:

HCFA MEDICAL NECESSITY INFORMATION

It is our policy to provide health care providers with the ability to order only those lab tests medically necessary for the individual patient and to ensure that the convenience of ordering standard panels and custom profiles does not impact this ability. While we recognize the value of this convenience, indiscriminate use of panels and profiles can lead to ordering tests that are not medically necessary. Therefore, all tests offered in our panels and profiles can be ordered individually as well. If a component test is not listed individually on the request form, it may be written in the "OTHER REQUESTS" box. We encourage you to order individual tests or a less inclusive profile when not all of the tests included in the panel or profile are medically necessary for the individual patient.

MEDICARE BILLING INFORMATION

Medicare billing policy prevents us from submitting a Medicare claim for laboratory testing referred to us on hospital inpatients or hospital outpatients. For these samples, we will bill the sending location.

MATERNAL SERUM SCREENING

1. The purpose of maternal serum screening is to identify pregnancies that may be at increased risk for open neural tube defects (ONTD), Down syndrome, or trisomy 18.
2. Estimated detection rates for screening tests:
 - Integrated Screen-(with NT)**-detects 80% of ONTD, 90% of Down syndrome, and 90% of trisomy 18.
 - Serum only Integrated Screen (no NT)**-detects 80% of ONTD, 85% of Down syndrome and 90% of trisomy 18.
 - First Trimester Only**-detects 83% of Down syndrome and 80% of trisomy 18; no information about ONTD.
 - Quad Screen, 2nd trimester only**-detects 80% of ONTD, 84% of Down syndrome, and 73% of trisomy 18.
 - AFP, 2nd trimester only**-detects 80% of ONTD. No information about trisomy 18 or Down syndrome.
3. Not all affected fetuses can be detected: Some will be missed by these screening tests. Some women with normal fetuses will have abnormal screening results.
4. Twins: Reported ONTD and Down risks are not as reliable as for singleton pregnancies and are supplied as approximate risks. Trisomy 18 risks are not provided.
5. Risk assessment cannot be done for pregnancies with more than 2 fetuses.

Gestational Age Calculation Information:

CRL measurement is used to calculate the gestational age for Integrated Screen 1st trimester and 1st Trimester Only tests.

Providers **MUST CHOOSE** at least one gestational age (LMP or US) to be used for interpretation of non-Integrated results. Gestational Age by US will be used if more than one provided.

ONLINE LAB TEST INFORMATION DATABASE

An online database of lab test information is now available at website:

byblos.labmed.washington.edu

The database contains information on test names and battery components, specimen collection, special handling, testing frequency, CPT codes and reference ranges. One can search either by test name or the lab mnemonics shown in [] on the front side of this requisition.

GENETIC COUNSELING MAY BE INDICATED FOR ABNORMAL RESULTS.

Additional information is available at the
UWMC Prenatal Genetics Department.
Phone number is 206-598-8130.

NUCHAL TRANSLUCENCY (NT) INFORMATION

Nuchal translucency (NT) quantitation is used as part of integrated screening risk calculations when measured by a certified practitioner. If a Prenatal Integrated Screen is ordered, and either a sonographer certification code or an NT measurement is not provided, the risk for Down syndrome and Trisomy 18 will be calculated using serum analytes only.

The mandate that NT measurements be provided only by certified practitioners can be viewed on the ACOG Practice Bulletin, Number 77, January, 2007. [Clinical Management Guidelines for Obstetrician-Gynecologists](#).

More information about the required certification can be found at the Fetal Medicine Foundation website www.fetalmedicine.com or the Nuchal Translucency Quality Review website www.ntqr.org

CMS MEDICAL NECESSITY INFORMATION

It is our policy to provide health care providers with the ability to order only those lab tests medically necessary for the individual patient and to ensure that the convenience of ordering standard panels and custom profiles does not restrict this ability. While we recognize the value of this convenience, indiscriminate use of panels and profiles can lead to ordering tests that are not medically necessary. Therefore, all tests offered in our panels and profiles can be ordered individually as well. If a component test is not listed individually on the request form, it may be written in the "OTHER REQUESTS" box. We encourage you to order individual tests or a less inclusive profile when not all of the tests included in the panel or profile are medically necessary for the individual patient.