IOWA State Hygienic Laboratory

Maternal Screen First Trimester/Integrated Test Request Form Reference Guide

****Forms that are incomplete (missing required information) will be returned and a new form will be requested before testing can be performed.****

Directions: Use the corresponding numbered, colored boxes to reference further information for the given section. For example, there is a reddish brown oval (numbered “1”) surrounding “Client Reference (Patient ID/MRN/Chart ID)” and it corresponds with the same color (reddish brown) text box below it (numbered “1”) that provides further explanation on the use of this field. Use this technique to reference the different sections while filling out the test request form.

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1.

FACILITIES, PLACE YOUR PATIENT INFORMATION LABEL HERE
OR
COMPLETELY FILL OUT INFORMATION BELOW

State Hygienic Laboratory at the University of Iowa

U of I Research Park
2490 Crosspark Road
Coralville, IA 52241-4721
Phone # 319-335-4500 or 800-421-IOWA

Ankeny Laboratory
2220 S. Ankeny Blvd.
Ankeny, IA 50023-9093
Phone # 515-725-1600

Lakeside Laboratory
1838 Highway 86
Milford, IA 51351-7267
Phone # 712-337-3669

http://www.shl.uiowa.edu

-If you have a patient information label that includes all of the patient information, place it here **OR** complete section 2 below with all required patient information.

2.

Iowa Maternal Screen First Trimester/Integrated Test Request Form

PATIENT INFORMATION — **Sample must have two patient identifiers that match this form.**

Client Reference (Patient ID/MRN/Chart ID) 1 | Last Name 2 | Legal First Name 3 | Middle Name

Birth Date 4 | Address 9 | City | State | Zip Code | Area Code/Phone # 6

Gender 5: ☐ Female ☐ Male ☐ Unknown

Race 8: ☐ White ☐ Black ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Unknown

Ethnicity 7: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

INSURANCE: SHL does not participate in private insurance. To have SHL bill public insurance, check the appropriate box and enter the patient's Insurance ID#, Diagnosis Code, and provider information.

Public Insurance: 10 ☐ Medicaid ☐ Medicare ☐ Amerigroup Iowa MCO ☐ Iowa Total Care MCO

Insurance ID# 11 | Diagnosis Code 12

-Enter the patient ID, medical record number, or chart ID. 1

-Enter the patient's last name. 2

-Enter the patient's legal first name. 3

-Enter the patient's date of birth (MM/DD/YYYY). 4

-Select the patient's gender. 5

-Enter the patient's telephone number with the area code. 6

-Select the patient's ethnicity. 7

-Select the patient's race. This is necessary for accurate risk assessment. 8

-Enter the patient's permanent address with the residing city, state, and zip code. 9

-Select the appropriate insurance, if primary insurance is public and is to be billed. 10

-Enter the patient's insurance ID number (also known as the member ID on the insurance card). 11

-Enter the patient's diagnosis code regarding the insurance claim. This contains information on the patient's condition/ procedure to support the insurance claim. 12

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3.

ORDERING HEALTH CARE PROVIDER INFORMATION

Last Name 1 | First Name 2 | NPI 3 | Area Code/Phone # 4

-Enter the healthcare provider's last name. (This would be the provider ordering the test.) 1

-Enter the healthcare provider's first name. (This would be the same provider ordering the test.) 2

-Enter the National Provider Identification number for this provider. 3

-Enter this provider's telephone number (with the area code) that SHL can contact with further questions if necessary. 4

4.

ORGANIZATION INFORMATION (Results are reported to this address. Organizations are responsible for submitting claims to private insurance.)

Organization Id 1 | Organization Name 2 | Address 1 3

Address 2 4 | City 5 | State | Zip Code

-The organization's identification number that patient results are to be reported to. 1

-The organization's name that the patient results are to be reported to. 2

-The organization's address line 1. 3

-The organization's address line 2. 4

-The organization's city, state, and zip code. 5

5.

SAMPLE INFORMATION (Check appropriate sample type and complete requested information. Only one sample per form.)

Date Collected / / 1 | Time Collected (24 hr. clock) : 2 | Sample Type ☐ Serum (2 mL) 3

-Enter the date the sample was drawn/collected from the patient (MM/DD/YYYY). 1

-Enter the time the sample was drawn/collected from the patient (24-Hour clock, 00:00-23:59). 2

-Check the sample type. For these tests the sample type should be serum (2 mL). 3

NOTE There should only be one sample per form submitted.

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6.

TEST REQUESTED (Select only one)

☐ First Trimester Screen 1

Integrated Screen

2 ☐ Sample 1 3 ☐ Sample 2

If patient has had Non-Invasive Prenatal Testing (NIPT) only order the NTD Screen on the Iowa Maternal Screen NTD/Quad Test Request Form.

-This tests for Down syndrome and Trisomy 18
-Should be drawn in the first trimester in the gestational age window 10weeks-13weeks6days.
-Crown Rump Length should be between 32-80 mm.
-For NT measurement a certified sonographer is required. 1

-Should be drawn in first trimester in the gestational age window 10weeks-13weeks6days.
-Crown Rump Length should be between 32-80 mm. 2

-This tests for Down syndrome, Trisomy 18, and open neural tube defects.
-Should be drawn in the second trimester in the gestational age window 15weeks-20weeks6days 3

7.

REQUIRED CLINICAL INFORMATION (Missing information will cause a delay in results.)

- By providing all information listed below, the most accurate patient-specific risk can be calculated.

In-Vitro Fertilization (IVF) using Egg Donor or Frozen Egg? ☐ Yes ☐ No 1

If patient's own egg, provide patient's age at time of egg retrieval: _____ yrs 2

If egg donor (other than patient) or donor embryo, provide donor's age at time of egg retrieval: _____ yrs 3

Patient's Weight: _____ lbs **or** _____ kg 4

Race Black? ☐ Yes ☐ No 5

Is the patient taking insulin for diabetes? ☐ Yes ☐ No 6

Family history of NTD (previous pregnancy, patient or father of baby have NTD)? ☐ Yes ☐ No 7

Ultrasound Date: 8 ___/___/___

Crown Rump Length (CRL): _____ mm 9or _____ cm

Required for First Trimester Screen/Requested for Integrated Screen
If the Nuchal Translucency (NT) measurement is > or = 3.0 mm, order the First Trimester Screen in place of the Integrated Screen.

Nuchal Translucency (NT) measurement: _____ mm 10

Sonographer Name: _____ 11

-Select if the patient had an egg donor or a frozen egg used for this pregnancy. 1

-Enter the patient's current weight in pounds or kilograms. 4

-Select if the patient, patient's previous pregnancy, or father of the baby has had a neural tube defect. 7

-Certified sonographer enters the nuchal translucency measurement in mm. 10

-Enter the age of the patient WHEN the egg was retrieved. 2

-Select if the patient is Black. This is needed for an accurate risk assessment. 5

-Enter the date that the ultrasound was performed (MM/DD/YYYY); used for testing purposes. 8

-Enter certified sonographer's name that did the ultrasound.
-The sonographer must be on file with the lab to submit the above measurement. 11

Enter the age of the egg donor at the time of egg collection. 3

-Select if the patient is currently taking insulin for diabetes. 6

-Enter the Crown Rump Length measurement in mm or cm. (This is the measurement from the top of the head to the bottom of the buttocks.) 9

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8.