

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.



(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.

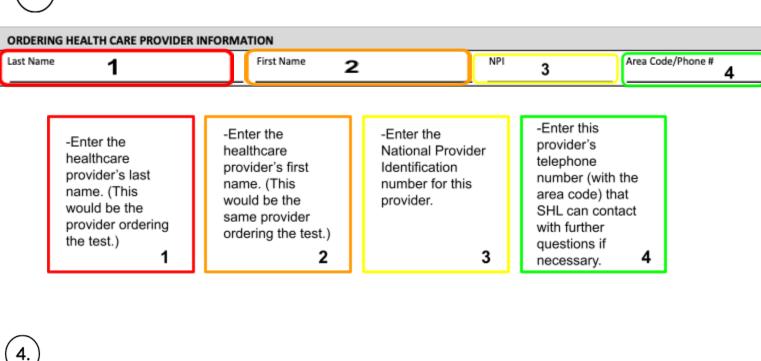
2.

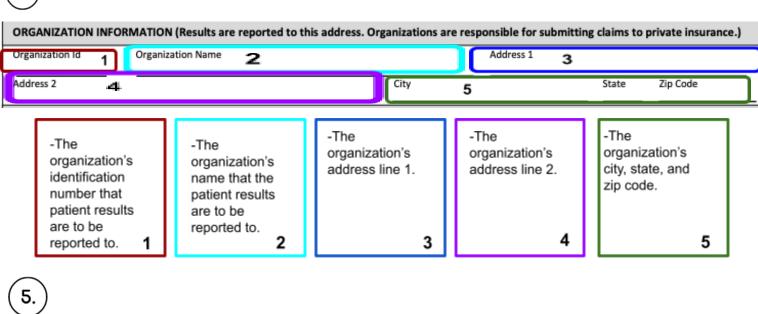
Iowa Maternal Screen First Trimester/Integrated Test Request Form

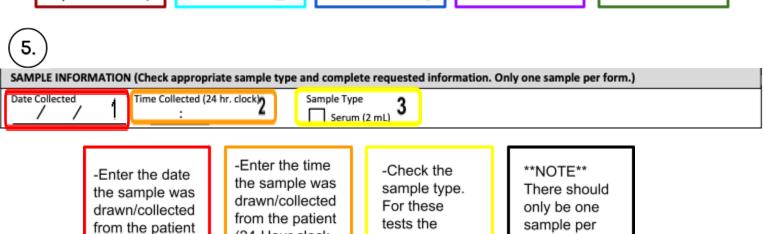
| PATIENT INFORMATION | | Sample must have two patient identifiers that match this form. | | | | | | | | |
|--|-----------------------|---|---|--|-----------------|------|--|--|--|--|
| Client Reference (Patient ID/MRN/Chart ID | | st Name 2 | | Legal First Name 3 | Middle Name | | | | | |
| Birth Date 4/ Address | | 9 ^{City} | | State Zip Code | Area Code/Phone | e# 6 | | | | |
| Gender Female Male Unknown White Black Asian American Indian/Alaskan Native Native Hawaiian/Pacific Islander Unknown | | | | | | | | | | |
| Ethnicity 7 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# | 1-1 | Diag | | Diagnosis Code12 | : | | | | | |
| -Enter the patien medical record number, or chart | na | Enter the patient's last ame. | | -Enter the patient's legal first name. | | | | | | |
| -Enter the pati date of birth (MM/DD/YYYY | eill's | -Select the patient's gender. 5 | | -Enter the patient's telephone number with the area code. | | | | | | |
| -Select the pat ethnicity. | T | Select the patient's race. 8 This is necessary for accurate risk assessment. | | -Enter the patient's permanent address with the residing city, state, and zip code. | | | | | | |
| -Select the app insurance, if pri insurance is pu is to be billed. | imary i blic and (| -Enter the patient's insurance ID number (also known as the member ID on the insurance card). | | -Enter the patient's diagnosis code regarding the insurance claim. This contains information on the patient's condition/ procedure to support the insurance claim. | | | | | | |
| | 10 | 11 | Ш | 12 | | | | | | |



(3.







sample type

serum (2 mL).

should be

form

submitted.

(24-Hour clock,

00:00-23:59). 2

(MM/DD/YYYY).



6.

TEST REQUESTED (Select only one)

| ☐ First I | rimester Screen 1 | Integrated Scre | een | | | | | | | | |
|--|--|---|--|--|--|--------------|--|--|--|--|--|
| | | 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-13weeks6daysCrown Rump Length should be between 32-80 mmFor NT measurement a certified sonographer is required. | | | -Should be drawn in first trimester in the gestational age window 10weeks-13weeks6days -Crown Rump Length should be between 32-8 mm. | open neural tube -Should be drawr second trimester gestational age w | ny 18, and defects. n in the in the vindow | | | | | | |
| 7. | | | | ···· , ········ | | | | | | | |
| | CLINICAL INFORMATION (| _ | cause a delay in results.) e patient-specific risk can be calc | ulated | | | | | | | |
| | tilization (IVF) using Egg Donor | | | rasound Date: 8 | | | | | | | |
| III-VILIO PET | tilization (IVF) using Egg Donor | or Prozeri Egg: res | 1007 | rasound Date. 8 | | | | | | | |
| If patient's own egg, provide patient's age at time of egg retrieval: yrs2 Crown Rump Length (CRL): mm 9r | | | | | | | | | | | |
| If egg donor at time of eg | r (other than patient) or donor gg retrieval: yrs | embryo, provide donor's age | [•] З | | | | | | | | |
| Patient's W | eight: Ibs | or kg | 4 | ired for First Trimostor Fore | on/Bonnested for Inter | rated Caroon | | | | | |
| Race Black? | Yes No | 5 | If the | i red for First Trimester Scre Nuchal Translucency (NT) m rst Trimester Screen in plac | neasurement is > or = 3.0 | mm, order | | | | | |
| Is the patier | nt taking insulin for diabetes? | Yes No 6 | Nu | chal Translucency (NT) mea | surement: | mm 1 0 | | | | | |
| Family histo | ory of NTD (previous pregnancy, patie | nt or father of baby have NTD)? | Yes No Sor | es No Sonographer Name: | | 11 | | | | | |
| | | | | · | | | | | | | |
| | -Select if the patient had an egg donor or a frozen egg used for this pregnancy. | -Enter the patient's current weight in pounds or kilograms. | -Select if the patient patient's previous pregnancy, or father the baby has had a neural tube defect. 7 | enters the nucl | nal | | | | | | |
| | -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) | name that did -The sonograp file with the lab | | l. n | | | | | |
| | Enter the age of the egg donor at the time of egg | -Select if the patient is currently taking insulin for | •• | rown Rump Length measurement in mm or the measurement from the top of the head to f the buttocks.) | | | | | | | |

diabetes.

3

collection.





FACILITIES, PLACE YOUR ELECTRONIC INTERFACE LABEL HERE

FOR STATE HYGIENIC LAB USE ONLY

3

-This space is used for internal lab use only. We need this space for labeling to sort the forms at the lab. Space is needed or samples will be delayed.

1

-Place electronic interface label (if applicable) in this space for ease of SHL processing.

-Leave this space empty.

3

2