Cleveland Clinic Laboratories
2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

PRENATAL SCREEN REQUISITION
QUAD4 AND AFPMAT

<<FORM_ID>>

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name | First | MI

Address | Birth Date | Sex ☐ M ☐ F

City | SS #

State | Zip | Home Phone

Hospital/Physician Office Patient ID # | Accession #

CLIENT INFORMATION

INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK)

BILL TO: ☐ Client/Institution ☐ Medicare ☐ Insurance (Complete insurance information below) ☐ Patient

PATIENT STATUS: ☐ Inpatient ☐ Outpatient ☐ Non-Hospital Patient Hospital discharge date: _____/_____/_____

PRIMARY: ☐ Medicare ☐ Medicaid ☐ Other Ins. _____ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name | First | MI

Beneficiary / Member # | Group #

Claims Address | City | State | Zip

SECONDARY: ☐ No ☐ Yes (if Yes, please attach)

ORDERING PHYSICIAN CONTACT

Physician Name

Physician NPI#

Physician Phone

Physician Email

☐ Call Results to phone number: (_____) _____

☐ Fax report to: (_____) _____

☐ Send additional report _____

INDICATE TESTS REQUIRED

☐ Quad Marker (Alpha-Fetoprotein, HCG, Estriol, Inhibin) *QUAD4*

☐ Alpha-Fetoprotein, Maternal (serum) *AFPMAT*

THE FOLLOWING INFORMATION IS REQUIRED AND MUST ACCOMPANY 2 mL OF SERUM

Specimen must be drawn between 15.0 weeks – 21.9 weeks (21 weeks 6 days) gestation

Draw Date: _____/_____/_____ Date of Birth: _____/_____/_____

ETHNICITY: ☐ Caucasion ☐ African-American ☐ Other _____

Is patient an insulin-dependent diabetic? ☐ Yes ☐ No

WEIGHT: _____ lbs

Does THIS patient have any previous pregnancies with a fetus or child having a neural tube defect (NTD)? ☐ Yes ☐ No

If Yes, one fetus/child with a NTD_____ or ≥ 2 fetus/children with NTDs_____

Estimation of Gestational Age (Choose only ONE assessment, whichever provides the MOST ACCURATE gestational age estimate:

EITHER a) Last Menstrual Period: _____/_____/_____

OR b) Ultrasound Date: _____/_____/_____

WITH Gestational Age **on date of ultrasound** _____ weeks _____ days

Pregnancy is: ☐ Single ☐ Twins ☐ Triplets

Was there a fetal demise in this pregnancy? ☐ Yes ☐ No

Previous Down syndrome pregnancy? ☐ Yes ☐ No

Is this an IVF or infertility pregnancy? ☐ Yes ☐ No

If Yes: Donor date of birth: _____/_____/_____ OR Donor age _____

Date of egg transfer: _____/_____/_____

Do you currently smoke cigarettes? ☐ Yes ☐ No

FOR INTERNAL LAB USE ONLY

LABEL

MEASUREMENTS LABEL

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