Maternal Serum Screening

Greenwood Genetic Center, 106 Gregor Mendel Circle, Greenwood, SC 29646

Please Print All Information

Social Security Number ______________________________

Name ____

Date of Birth _________________ Age _______________

Address ____

City ________________ State ________ Zip ____________

Phone (Home) _____________ (Office) _______________

1. Do you have insulin dependent diabetes? Yes No
2. Do you have epilepsy (seizures)? Yes No
3. Do you take medication for seizures? Yes No
   Name of seizure medication:
4. Has anyone in your family or the babyøs fatherøs family had a neural tube defect? Relationship? Yes No
5. Has anyone in your family or the babyøs fatherøs family had Down syndrome? Relationship? Yes No
6. Do you smoke? If yes, how much? Yes No

For Laboratory Use Only

Study# _______________ Guar.# _________________

AFP IU/mL _________ MoM __________

hCG IU/mL _________ MoM __________

uE3 ng/mL _________ MoM __________

DIA pg/mL _________ MoM __________

T18 Risk _________ DS Risk __________

Information Required By Requesting Physician

ˇ **Quad Screen** (AFP, hCG, uE3, DIA) î **AFP** (NTD Screening only)

1. Date of Sample ______________________________
2. Is this a repeat sample for this pregnancy? î Yes î No
3. Patientøs Current Weight _______________________
4. Race: î Wh î Bl î Hispanic î Other _________
5. Twin Pregnancy? î Yes î No
6. Gestational age on date of sample ______ wks _____ days

   î Ultrasound (BPD) EDC by scan _____________

   î LMP__________ EDC by LMP_____________
7. Gravida ________ Para _________ Ab __________
8. Physician/Clinic _____________________________
9. Please provide the requesting physicians NPI # _________

Billing Information – Important – Complete all information or enclose copy of insurance card front and back.

Medicaid Coverage _____ Yes _____ No Medicaid number __________________________

Primary Insurance Coverage

Name of Insured ____________________________ Date of Birth ___________ Relationship ________________________

Place of Employment of Insured ____

Insurance Company ____

Address of Ins. Co. **(Required for filing insurance)** ____

Policy# (or Soc.Sec.#) of Insured _________________________ Plan# ___________________________

Secondary Insurance Coverage

Name of Insured ____________________________ Date of Birth ___________ Relationship________________________

Place of Employment of Insured ____

Insurance Company ____

Address of Ins. Co. **(Required for filing insurance)** ____

Policy# (or Soc.Sec.#) of Insured_________________________ Plan#___________________________

î I have read the brochure on maternal serum screening for neural tube defects and Down syndrome and authorize the testing of my blood sample and the use of the results in evaluating the screening program.

î I authorize the release of any medical or other information necessary to process an insurance claim. I authorize payment of benefits to Greenwood Genetic Center for these services.

î After my testing is complete, I agree that any remaining blood sample may be used for research.

î I authorize future contact with me regarding the outcome of my pregnancy.

Signature ____ Date ____________________________