**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.
State Hygienic Laboratory at the University of Iowa

- 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.

### Iowa Maternal Screen First Trimester/Integrated Test Request Form

<table>
<thead>
<tr>
<th>PATIENT INFORMATION</th>
<th>Sample must have two patient identifiers that match this form.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Reference (Patient ID/MRN/Chart ID)</td>
<td>Last Name</td>
</tr>
<tr>
<td>Birth Date</td>
<td>Address</td>
</tr>
<tr>
<td>Gender</td>
<td>Race</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Instructions:

1. Enter the patient ID, medical record number, or chart ID.
2. Enter the patient’s last name.
3. Enter the patient’s legal first name.
4. Enter the patient’s date of birth (MM/DD/YYYY).
5. Select the patient’s gender.
6. Enter the patient’s telephone number with the area code.
7. Select the patient’s ethnicity.
8. Select the patient’s race. This is necessary for accurate risk assessment.
9. Enter the patient’s permanent address with the residing city, state, and zip code.
10. Select the appropriate insurance, if primary insurance is public and is to be billed.
11. Enter the patient’s insurance ID number (also known as the member ID on the insurance card).
12. Enter the patient’s diagnosis code regarding the insurance claim. This contains information on the patient’s condition/procedure to support the insurance claim.

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### ORDERING HEALTH CARE PROVIDER INFORMATION

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

1. Enter the healthcare provider's last name. (This would be the provider ordering the test.)
2. Enter the healthcare provider's first name. (This would be the same provider ordering the test.)
3. Enter the National Provider Identification number for this provider.
4. Enter this provider’s telephone number (with the area code) that SHL can contact with further questions if necessary.

### 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 |

1. The organization’s identification number that patient results are to be reported to.
2. The organization’s name that the patient results are to be reported to.
3. The organization’s address line 1.
4. The organization’s address line 2.
5. The organization’s city, state, and zip code.

### 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 3 |

1. Enter the date the sample was drawn/collected from the patient (MM/DD/YYYY).
2. Enter the time the sample was drawn/collected from the patient (24-Hour clock, 00:00-23:59).
3. Check the sample type. For these tests, the sample type should be serum (2 mL).

**NOTE**
There should only be one sample per form submitted.
6. TEST REQUESTED (Select only one)

- First Trimester Screen 1
- Sample 1 2
- Sample 2 3

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 10 weeks-13 weeks 6 days.
- Crown Rump Length should be between 32-80 mm.
- For NT measurement a certified sonographer is required.

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

- In-Vitro Fertilization (IVF) using Egg Donor or Frozen Egg? [ ] Yes [ ] No

If patient’s own egg, provide patient’s age at time of egg retrieval: _____ yr

If egg donor (other than patient) or donor embryo, provide donor’s age at time of egg retrieval: _____ yrs [ ] Yes [x] No

Patient’s Weight: _____ lbs or _____ kg

Race Black? [ ] Yes [ ] No

Is the patient taking insulin for diabetes? [ ] Yes [ ] No

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

Ultrasound Date: 8/__/____

Crown Rump Length (CRL): _____ mm 9 [ ] 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

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 of the baby has had a neural tube defect.

- Certified sonographer enters the nuchal translucency measurement in mm.

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

- Enter certified sonographer’s name that did the ultrasound.

- The sonographer must be on file with the lab to submit the above measurement.

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

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

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

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

- 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.)
- 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.

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

- Leave this space empty.