Maternal Screen NTD/Quad 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.
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.

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Iowa Maternal Screen NTD/Quad Test Request Form

- 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. 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

Insurance ID:

Diagnosis Code:
### ORDERING HEALTH CARE PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>Last Name</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td>2</td>
</tr>
<tr>
<td>NPI</td>
<td>3</td>
</tr>
<tr>
<td>Area Code/Phone #</td>
<td>4</td>
</tr>
</tbody>
</table>

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.)

<table>
<thead>
<tr>
<th>Organization Id</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization Name</td>
<td>2</td>
</tr>
<tr>
<td>Address 1</td>
<td>3</td>
</tr>
<tr>
<td>Address 2</td>
<td>4</td>
</tr>
<tr>
<td>City</td>
<td>5</td>
</tr>
<tr>
<td>State</td>
<td>6</td>
</tr>
<tr>
<td>Zip Code</td>
<td>7</td>
</tr>
</tbody>
</table>

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.)

<table>
<thead>
<tr>
<th>Date Collected</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Collected</td>
<td>2</td>
</tr>
<tr>
<td>Sample Type</td>
<td>3</td>
</tr>
<tr>
<td>Amniotic Fluid (AFP only)</td>
<td>4</td>
</tr>
</tbody>
</table>

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. Serum sample could be drawn for either test listed below. See below for more information.
4. Check the sample type. Select amniotic fluid if sample was obtained during amniocentesis.

**NOTE**
There should only be one sample per form submitted.
<table>
<thead>
<tr>
<th>Test Requested (Select only one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quad Screen (Order NTD Screen for twin pregnancy.)</td>
</tr>
</tbody>
</table>

If patient has had Non-Invasive Prenatal Testing (NIPT) only order the NTD Screen.

- This tests for Down syndrome, Trisomy 18, and open neural tube defects
- This serum sample should be drawn in the second trimester in the gestational age window of 15 weeks-20 weeks 6 days.
- Order this test for a twin pregnancy.
- This tests for open neural tube defects.
- A serum sample should be drawn in the second trimester in the gestational age window 15 weeks-20 weeks 6 days.
- An amniotic fluid sample should be obtained during amniocentesis in the gestational age window 13 weeks 5 days-22 weeks 6 days.

**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.

<table>
<thead>
<tr>
<th>In-Vitro Fertilization (IVF) using Egg Donor or Frozen Egg?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

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: __________ yr

Patient’s Weight: ___________ lbs or ___________ kg

Race Black? Yes | No

Number of fetuses: 1 | 2 | Note: Risk estimate not available for 3 or more fetuses.

Is the patient taking insulin for diabetes? Yes | No

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

Date of first day of Last Menstrual Period: __________

Ultrasound Date: __________

Crown Rump Length (CRL): __________ mm or __________ cm

Twin Crown Rump Length (CRL): __________ mm or __________ cm

OR Biparial Diameter (BPD): __________ mm or __________ cm

Twin Biparial Diameter (BPD): __________ mm or __________ cm

OR Weeks and Days at ultrasound: __________

Twin Weeks and Days at ultrasound: __________

- 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.
- Enter the date of the patient's last menstrual period. (Use the first day in the last cycle.)
- Enter the crown rump length for Twin B.
- Enter the BPD in mm or cm if no crown rump length measurement is available. This is for one fetus or Twin A. (This is the diameter of the baby's head.)
- Enter how far along the pregnancy is/was at the time of the ultrasound for one fetus or Twin A.
- Enter how far along the pregnancy is/was at the time of the ultrasound for Twin B.
-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.