University of North Carolina Health Care
McLendon Lab Outreach Program
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MATERNAL SERUM REQUEST FORM

EPIC Order #

LAB USE ONLY

Date of Sample _____ / _____ / _____ **UNC MR#**_____ **DOB** _____ / _____ / _____

Patient Name _____ _____
Last Name **First Name**

Address _____ **County**_____

City/State _____ **Zip Code** _____

LMP Date ____/____/____ **Ultrasound Date** (if done) ____ / ____ / ____ **Gestational age on day of ultrasound** ___ **weeks** ___ **days**

Number of fetuses _____

Weight_____ lbs **Race/Ethnicity:** ◯White ◯Black ◯Hispanic ◯Asian ◯American Indian ◯Other

Is this patient an insulin-dependent diabetic (prior to pregnancy)? ◯Yes ◯No
Prior pregnancy history of: Spina Bifida or Anencephaly? ◯Yes ◯No
Prior pregnancy history of: Down Syndrome? ◯Yes ◯No
Has the patient smoked at any time during this pregnancy? ◯Yes ◯No

Is this a repeat sample? ◯Yes ◯No If yes, specimen code of first sample _____

PROVIDER/HEALTH CLINIC INFORMATION (required)
Clinic Health Department

_____
_____
_____

Direct Phone number_____

Provider Printed Name _____

Provider NPI Number_____

TEST REQUESTED (Check one box only)
To be performed between 15 0/7 and 22 6/7 weeks

◯Quadruple Screen (AFP, hCG, uE3, Inhibin-A)
(for second trimester Down syndrome, trisomy 18, neural tube defect (NTD) and Smith-Lemli-Opitz syndrome testing)

◯AFP (NTD) ONLY
(for patients who had CVS, first trimester screening or 1 positive NTD screen)

ICD-10 CODE (required):_____

BILLING INFORMATION

☐**Medicaid** ☐**Presumptive Medicaid** ☐**Indigent** ☐**Self Pay** ☐**Medicare** ☐Insurance

Medicaid ID#_____

Company Name_____

Member/Insured ID# _____

ALL OPTIONS OTHER THAN INDIGENT OR SELF PAY REQUIRE COPY OF INSURANCE CARD/INFORMATION

Relationship to insured ◯Self ◯Spouse ◯Dependent

Consent: I understand that the Quad/AFP screen may not find ALL babies with neural tube defects, Trisomy 18, SLOS or Down Syndrome. I understand a positive test does not mean my baby has a birth defect. A positive test means the chance for a birth defect is higher than average and additional tests will be offered. I agree to the testing of my blood sample.

Patient's signature _____ Date _____ / _____ / _____

White copy–Outreach Yellow copy–Laboratory Pink copy–Retain for your records