

**Requisition for submitting
FIRST or SECOND TRIMESTER SAMPLES
for Prenatal Screening**



Mailing Address:
P.O. Box 190
Scarborough, ME 04070-0190

Shipping Address:
8 Science Park Road
Scarborough, ME 04074

Tel: (207) 883-4131
toll free: 1-800-639-8605
FAX: (207) 883-1379
www.fbr.org

PLEASE CHECK: BILL SENDER BILL PATIENT BILL INSURANCE
If insurance information or patient address are not provided, charges will be submitted to Sender

PATIENT NAME: LAST, FIRST MIDDLE	
BILLING ADDRESS (STREET No. or P.O. BOX)	
CITY	STATE ZIP CODE
DATE OF BIRTH	SEX: M F
	SAMPLE DRAW DATE
REFERRING DOCTOR	
PATIENT ID/ACCOUNT CODE	HOSP. LAB ORDER CODE

BEST RESULTS IF BLOOD DRAWN BETWEEN ____/____/____ AND ____/____/____	
SENDER: (Hospital or Laboratory name & address)	FOR FBR USE ONLY

FOR PATIENT OR INSURANCE BILLING --- COMPLETE THE INFORMATION BELOW	
SUBSCRIBER	
INS. CO. NAME	
ID CERT. NO.	
GROUP NO.	
STATE	
Information relative to these testing services may be requested from or released to third parties for the purposes of clinical assessment or to process claims for payment of benefits.	

CHECK TEST(S) REQUESTED

First Trimester (10w,3d - 13w,6d ga)

INTEGRATED SCREEN Part 1 (PAPP-A component)
Full Integrated requires 1st trimester NT measurements
Serum Integrated needs only the 1st trimester sample

SEQUENTIAL SCREEN Part 1 (PAPP-A component)
requires nuchal translucency (NT) measurements

FIRST TRIMESTER SCREEN (PAPP-A, hCG, Inhibin)
requires nuchal translucency (NT) measurements

Unless this box is checked, any remaining sample and clinical information may be used to develop future laboratory tests.

Second Trimester (15-21 wks ga)

INTEGRATED SCREEN Part 2 (AFP, Estriol, hCG, Inhibin plus an ultrasound dated 1st trimester PAPP-A component)

SEQUENTIAL SCREEN Part 2 (AFP, Estriol, hCG, Inhibin plus an ultrasound dated 1st trimester PAPP-A component)

AFP PROFILE FOUR (AFP, Estriol, hCG, Inhibin)

AFP ONLY -- for NTD screening only

PART A Dating information is required for interpretation of results

LMP date: ____/____/____ U/S date: ____/____/____ GA on U/S date: ____ wks, ____ days Check box if by BPD

U/S date: ____/____/____ NT: ____ mm CRL: ____ mm Sonographer name: _____ Site where U/S done: _____

If twin pregnancy: twin B NT: ____ mm twin B CRL: ____ mm Chorionicity: Mono Di Unknown

PART B Patient background is required for proper risk assessment

Height: _____ Weight (lbs.): _____ **Race:** Caucasian Black Other

Pregnancy History: Vaginal bleeding this pregnancy? Y N **Insulin dependent diabetic** prior to this pregnancy? Y N

Cigarette smoker? Y N If yes, how many per day? _____ **Multiple pregnancy?** Y N If yes, number of fetuses: _____

Has the patient already had... **Fetal demise this pregnancy?** Y N If yes, explain (comments)

Amniocentesis? or CVS? date ____/____/____ **IVF this pregnancy?** Y N If donor egg, age of donor: _____

First trimester test for Down syndrome? date ____/____/____ **Previous pregnancy** diagnosed to have Down syndrome? Y N

COMMENTS

NTD Family history: (Spina bifida or Anencephaly)? Y N
If yes, describe:

CPT Codes by Components

First Trimester Screen	CPT
PAPP-A	84163
HCG	84702
Inhibin	86336
Sequential Screen Part 2 (see Integrated Screen Part 2)	
Integrated Screen Part 2	
PAPP-A	84163
AFP	82105
uE3	82677
hCG	84702
Inhibin	86336
AFP Profile Four	
AFP	82105
uE3	82677
hCG	84702
Inhibin	86336
AFP Only (serum)	82105
Cotinine (serum or urine)	83887
AFP (amniotic fluid)	82106
ACHE Analyses (amniotic fluid)	
ACHE	82013
Electrophoresis	82664
Scan	82143
Blood Contamination Studies	
Fetal Blood	86331
Maternal Blood	86185
BSA Contamination	86185