NTD LABS
from PerkinElmer
80 Ruland Rd., Ste. 1 Melville, NY 11747
631.425.0800

Specimen Collection and Test Requisition Form

2014-12

NTD LABS COPY

Drawn by: ____________ (Name)   Collection Date: ____________ (MM/DD/YY)   SN 2848416

Patient Information

Last Name ______ First Name ______ MI ______

Street Address ______ Apt # ______

City ______ State ______ Zip ______

Phone ( ) ______ Birth Date (MM/DD/YY) ______ Weight ______

Patient History

- ☐ Residence different during 1st Trimester
  If yes, specify Country ______ State ______
- ☐ Prior Pregnancy w/Down Syndrome
- ☐ Prior Pregnancy w/Trisomy 18
- ☐ Prior Pregnancy w/Trisomy 13
- ☐ Family History of Open Neural Tube Defects
  Relationship to patient ______

Ethnicity

- ☐ African American
- ☐ Ashkenazi Jewish
- ☐ Asian
- ☐ Asian Indian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Native American
- ☐ Other

Current Pregnancy

Due Date ______ (MM/DD/YY)   ☐ Ultrasound confirmed

- ☐ Insulin Dependent Before Pregnancy
- ☐ Valproic Acid (Depakene) or Cabamazepine (Tegretol) THIS Pregnancy
- ☐ Artificial Reproduction/In-Vitro: Age of Egg: ______ Years
- ☐ Twin   ☐ Multiple # ______   ☐ Smoker

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Physician Information

Ordering Physician ______   Physician Code # 4435

Sonographer ______   FMF# or NTQR# ______

Sonographer's Supervisor ______   FMF# or NTQR# ______

Referring OB/GYN *(if different from ordering)* ______   OB/GYN Phone # ______

Aneuploidy Screening

First Trimester (9w 0d - 13w 6d)   Ultrasound Date *(MM/DD/YY)* ______

- ☐ First Trimester Screen | Fβ *(free-Beta™ / PAPP-A / NT)*
- ☐ First Trimester Screen | Fβ with Nasal Bone *(must indicate Absent or Present)*

CRL (45-84mm) ___.__   NT (mm) __.__   Nasal Bone ☐ Absent ☐ Present

CRL (45-84mm) Twin B ___.__   NT (mm) Twin B __.__   Nasal Bone ☐ Absent ☐ Present

Twin Type ☐ Monochorionic ☐ Dichorionic

Second Trimester (15w 0d - 21w 6d)

- ☐ Afp Test (for ONTDs)   ☐ Check if repeat specimen for elevated MSAFP
- ☐ Double Screen | Fβ *(AFP / free-Beta™)*

Date of Ultrasound ______ (MM/DD/YY)   GA at Ultrasound ____ w ____ d

Carrier Testing

- ☐ Cystic Fibrosis Carrier Testing
- ☐ Male *(please provide female reproductive partner information)*

Female name ______

Female DOB ______ (MM/DD/YY)

Billing Information: PLEASE PROVIDE READABLE COPY OF BOTH SIDES OF YOUR INSURANCE CARD OR COMPLETE INSURANCE INFORMATION

Insurance Company ______   Subscriber's Name ______

Insurance ID # ______   Group # ______   Plan name ______

Insurance Claims Address ______ Street ______ City ______ State ______ Zip ______ Telephone ______

Referral / Authorization # ______   ☐ Payment Enclosed $ ______

PATIENT AUTHORIZATION / ASSIGNMENT. I authorize NTD Laboratories, Inc ("NTD") to obtain and release relevant medical and other information and to directly bill and submit claims to Medicare, Medicaid, Medicare Supplemental and/or other insurance providers ("Insurance") for laboratory/medical services that NTD provides to me. I assign insurance benefits to NTD and acknowledge that charges that are not covered by insurance, including any applicable co-payments and deductibles, are my responsibility and I agree to pay for such charges.

Signature: ______   Date: ______

Date Specimen Received ______

(affix barcode label here)

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APPLY ONLY ONE DROP TO EACH CIRCLE - DO NOT LAYER

Ahlstrom PerkinElmer 226   LOT 100535 / 311146