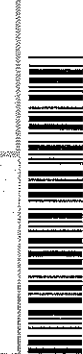


NTD LABS COPY Drawn by: _____ (Name)

Collection Date: _____ (MM/DD/YY) **SW** 2848416



4435

FOR NTD LABS USE ONLY

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 _____

Current Pregnancy

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

☐ Insulin Dependent Before Pregnancy

☐ Valproic Acid (Depakene) or Carbamazepine (Tegretol) THIS Pregnancy

☐ Artificial Reproduction/In-Vitro: Age of Egg: _____ Years

☐ Twin ☐ Multiple # _____ ☐ Smoker

FOR NTD LABS USE ONLY

Physician Information

Ordering Physician _____ Physician Code # _____

Sonographer _____ FMI# or NTQR# _____

Sonographer's Supervisor _____ FMI# or NTQR# _____

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

Aneuploidy Screenings

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

☐ First Trimester Screen | Fβ (free-Beta² / PAPP-A / NT)

☐ First Trimester Screen | Fβ with Nasal Bone (must indicate Absent or Present)

CRL (45-84mm) _____ NT (mm) _____ Nasal Bone _____ Twin Type _____

CRL (45-84mm) _____ NT (mm) _____ Absent ☐ Present ☐ Monochorionic ☐ Dichorionic

NT (mm) _____ Absent ☐ Present ☐ Monochorionic ☐ Dichorionic

NT (mm) _____ Absent ☐ Present ☐ Monochorionic ☐ Dichorionic

NT (mm) _____ Absent ☐ Present ☐ Monochorionic ☐ Dichorionic

NT (mm) _____ Absent ☐ Present ☐ Monochorionic ☐ Dichorionic

NT (mm) _____ Absent ☐ Present ☐ Monochorionic ☐ Dichorionic

NT (mm) _____ Absent ☐ Present ☐ Monochorionic ☐ Dichorionic

NT (mm) _____ Absent ☐ Present ☐ Monochorionic ☐ Dichorionic

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NT (mm) _____ Absent ☐ Present ☐ Monochorionic ☐ Dichorionic

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: _____

APPLY ONLY ONE DROP TO EACH CIRCLE - DO NOT LAYER



Antismarm ParkinEimer 226 LOT 100535 / 311146