University of Nebraska Medical Center REGIONAL PATHOLOGY SERVICES

Regional Pathology Services
University of Nebraska Medical Center
981180 Nebraska Medical Center
Omaha NE 68198-1180
www.reglab.org

Toll Free 1-800-334-0459
Phone (402) 559-6420
FAX (402) 559-9497

Quad Screen/MSAFP Only Test Request Form

SHADED AREAS FOR PATIENT INFORMATION REQUIRED

PATIENT LAST NAME | FIRST NAME | MI

DOB / / | GENDER ☐ MALE ☐ FEMALE | PT. ID# / ADDITIONAL INFO

SSN | BILL TO: ☐ RPS Client Account ☐ Patient Insurance | PT. PHONE ___ /___ /____

PATIENT INSURANCE
ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD AND ATTACH COPY OF FRONT OF DRIVERS LICENSE
IF UNABLE TO OBTAIN COPY OF REQUIRED INFORMATION ALL FIELDS BELOW ARE REQUIRED

GUARANTOR NAME/DOB (REQUIRED IF PATIENT IS A MINOR)

ADDRESS | CITY | STATE | ZIP

PRIMARY INSURANCE
☐ MEDICARE IN-PATIENT ☐ MEDICARE OUT-PATIENT ☐ MEDICAID ☐ INSURANCE

POLICY ID# | GROUP ID#

INSURANCE COMPANY | PHONE NUMBER

INSURANCE COMPANY ADDRESS | CITY | STATE | ZIP

EFFECTIVE DATE / /

DIAGNOSIS CODE (B)

ICD-9/10 #1 | ICD-9/10 #2 | ICD-9/10 #3

NOTICE: WHEN ORDERING TEST FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF A PATIENT RATHER THAN FOR SCREENING PURPOSES. FOR MORE INFORMATION SEE reglab.org/billingcompliance/

EACH TEST ORDERED MUST BE CODED WITH A DIAGNOSIS NUMBER

RPS Use Only

Accession #: ____________

COLLECTION DATE / / | TIME ___ AM ___ PM | REPORT ☐ CALL ☐ FAX | STAT ☐

PROVIDER: ____________ (First, Last, MI)

ACCOUNT NUMBER | ACCOUNT NAME
"If you do not know your account number, call Client Services at 482-550-2440

STREET ADDRESS OR PO BOX

CITY | STATE | ZIP CODE

PHONE NUMBER | FAX NUMBER

SECONDARY / TERTIARY INS - ATTACH INFORMATION

☐ ABN ATTACHED ☐ PRIOR AUTHORIZATION ATTACHED

EACH TEST ORDERED MUST BE CODED WITH A DIAGNOSIS NUMBER

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TEST TYPE & SPECIMEN INFORMATION

Select one test type: ☐ Quad Screen ☐ MS-AFP Only
☐ Initial Specimen ☐ Repeat

Collection Date & Time ____________

Specimen Requirements: 1 mL serum refrigerated
Results can be interpreted between 14 wks 0 d & 20 wks 6 d gestation

PREGNANCY INFORMATION

All Information provided below is necessary for interpretation of this test. Providing accurate and complete information will avoid delay in specimen processing and result reporting.

Patient Weight: ________ lbs.
Gravida: ______ Para: ______

Patient Ethnic Background: *(select all that apply)*
☐ African American ☐ Native American
☐ Asian ☐ Hispanic &/or Latino
☐ Caucasian ☐ Other

EDD: ________ Determined by: ☐ LMP ☐ U/S ☐ Exam
LMP *(if known)*: ________
Ultrasound Date: ________ (if available) or
Gestational Age: ______ w ______ d
Crown-Rump Length (CRL): ______ mm ______ cm
Biparietal Diameter (BPD): ______ mm ______ cm

1.)Is this pregnancy the result of an egg donor? ☐ Yes ☐ No
IF YES, egg donor's DOB: ________
2.)Twin gestation? ☐ Yes ☐ No
3.)Does the patient have insulin dependent diabetes? ☐ Yes ☐ No
4.)Does the patient have a family history of neural tube defect? ☐ Yes ☐ No
IF YES, relation to patient: ________
5.) Does the patient have a family history of Down Syndrome (Trisomy 21)? ☐ Yes ☐ No
Other family history concerns: ____________

RPQUAD 9.2.15