



Excellence in Pathology and Laboratory Services

Maternal Screen Testing Recalculation Request Form

Client Name & Acct #: _____

Person requesting change(s): _____

Must be client physician or designated employee; PathGroup phlebotomists may not request changes

Patient Name: _____ **D.O.B.:** (MM/DD/YY) _____

Last, First Middle Initial

Accession Number: _____ **Date of Service:** _____

PREGNANCY INFORMATION: (Enter Desired Changes Only)

	<i>Change from</i>	<i>Change to</i>		<i>Change from</i>	<i>Change to</i>
Estimated Date of Delivery (EDD)			Number of Fetuses		
EDD Determined by			Insulin Dependent		
LMP Date			Weight		
Current Gestational Age			Race		
Ultrasound Date			Screen- Initial or Repeat		
Gestational Age on Ultrasound Date			If IVF, Donor's Date of Birth or Age		
Gravida			Family History of Neural Tube Defects		
Parity			Maternal Date of Birth		

TEST CODE DESIRED: (Enter only if changes are required)

	Test Code	Test Name	ICD-9	COMMENTS
<input type="checkbox"/>	AFM20	Alpha- fetoprotein Maternal, 2.0 MoM		
<input type="checkbox"/>	AFP25	Alpha- fetoprotein Maternal, 2.5 MoM		
<input type="checkbox"/>	TRIP2	Alpha- fetoprotein Triple Marker Screen, 2.0 MoM		
<input type="checkbox"/>	AFT5	Alpha- fetoprotein Triple Marker Screen, 2.5 MoM		
<input type="checkbox"/>	QUAD2	Alpha- fetoprotein Quad Screen, 2.0 MoM		
<input type="checkbox"/>	AFQ5	Alpha- fetoprotein Quad Screen, 2.5 MoM		

PLEASE FAX THIS FORM BACK TO: 615-562-9301 or 866-325-5890

This form must be completed and returned via Fax to PathGroup immediately. For further inquiries, please call client services at 615-562-9300 or toll free at 888-474-5227

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