Magee-Womens Hospital Pregnancy Screening Laboratory

of the University of Pittsburgh Medical Center

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(412) 641-4878
(412) 641-4057
(412) 641-8730 (Fax)

FIRST TRIMESTER SCREENING REQUISITION

INCOMPLETE INFORMATION MAY RESULT IN DELAYED OR INACCURATE INTERPRETATION OF RESULTS. PLEASE PROVIDE *ALL* INFORMATION REQUESTED.

PATIENT INFORMATION (Please print)

LAST NAME _____ FIRST NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

DATE OF BIRTH _____ / _____ / _____ SOCIAL SECURITY NUMBER _____ / _____ / _____

RACE _____ WEIGHT (Pounds) _____

PREGNANCY/SPECIMEN INFORMATION

Specimen Date _____ / _____ / _____ Date of LMP _____ / _____ / _____

Ultrasound Date _____ / _____ / _____ Sonographer Name: _____

Twin Pregnancy? ☐ Yes ☐ No If Twins: ☐ Monochorionic ☐ Dichorionic ☐ Uncertain

Baby A

CRL: _____ (mm) = _____ (wk/day)

NT: _____ (mm)

If Twins, Baby B

CRL: _____ (mm) = _____ (wk/day)

NT: _____ (mm)

OB complications? _____ Major maternal diseases? _____

Is the patient diabetic? ☐ Yes ☐ No If yes, method of control? ☐ Insulin ☐ Diet ☐ Oral Meds _____

Assisted Reproduction? ☐ Yes ☐ No If donor egg, age of donor _____ yrs.
If frozen embryo, age at collection _____ yrs.

Maternal Smoking History? ☐ Yes ☐ No If yes number of cigarettes _____ per day.

FAMILY HISTORY (If yes, what is the relationship to the patient?)

Spina Bifida/Anencephaly ☐ Yes ☐ No _____

Down syndrome ☐ Yes ☐ No _____

Other Birth Defects - ☐ Yes ☐ No (If Yes, Describe) _____

REFERRING PHYSICIAN INFORMATION

(Please include a physician signature and diagnosis code if a script will not be accompanying the patient)

REFERRING PHYSICIAN (Print) _____ PHONE _____ FAX _____

(Signature) _____ DIAGNOSIS CODE _____

OFFICE ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____