UPMC
LIFE CHANGING MEDICINE

# UPMC Pregnancy Screening Laboratory

## FIRST TRIMESTER SCREENING REQUISITION

300 Halket Street
Pittsburgh, PA 15213-3180
(412) 641-4878 / 4057
(412) 641-8730 (Fax)

**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 ______ - _____ -__________

## PREGNANCY/SPECIMEN INFORMATION

Specimen Date: ____ / ____ / _______

Race: ____________________ Weight (Lbs) ___________

Date Of LMP ______ / ______ / ________

Composite (Wks) _________ Bpd (Wks) _________

Twin Pregnancy? ☐Yes ☐No

If Twins: ☐Monochorionic ☐Dichorionic ☐Uncertain

Is The Patient Diabetic? ☐ Yes ☐ No

If Yes, Method Of Control?

☐ Insulin ☐Diet ☐ Oral Meds ____________________

Ultrasound Date If Available: ______ / ______ / ________

Normal? ☐ Yes ☐No

(If No, List Abnormalities) ______________________________

Sonographer Name: ________________________

Baby A

CRL: ______ (mm) = _______ (wk/day)

NT: ______ (mm)

If Twins, Baby B

CRL: ______ (mm) = _______ (wk/day)

NT: ______ (mm)

IVF? ☐Yes ☐No If Yes, maternal age at time of egg retrieval:______ yrs If donor egg, age of donor: _____ yrs

Major Maternal Diseases/Ob Complications? ☐Yes ☐No If Yes, Describe: __________________________

Maternal Smoking? ☐Yes ☐No If Yes, number per day:_____

**Family History:**

If Yes, Relationship To Patient:

☐ Yes ☐ No Spina Bifida/Anencephaly ______________________________

☐ Yes ☐ No Down Syndrome ______________________________

☐ Yes ☐ No Other Birth Defects - 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: _________________

Revised 5/17/2021