Magee-Womens Hospital

Pregnancy Screening Laboratory

of the University of Pittsburgh Medical Center

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

MULTIPLE MARKER 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 _____ - _____ -_____

PREGNANCY/SPECIMEN INFORMATION

Specimen Date: ____ / ____ / _____ ☐ First Sample ☐ Repeat Sample

Race: _____ Weight (Lbs) _____

Did Patient Have:

CVS? ☐ Yes ☐ No

First Trimester Screen*? ☐ Yes ☐ No

cfDNA ☐ Yes ☐ No

* Do You Want AFP Only?

Is The Patient Diabetic? ☐ Yes ☐ No If Yes, Method Of Control? ☐ Insulin ☐ Diet ☐ Oral Meds _____

Date Of LMP _____ / _____ / _____ Ultrasound Date If Available: _____ / _____ / _____

Bpd (Wks) _____ Composite (Wks) _____ Normal? ☐ Yes ☐ No (If No, List Abnormalities) _____

Multiple Pregnancy? ☐ Yes ☐ No ☐ Twins ☐ Other (#) _____

IVF? ☐ Yes ☐ No If Yes, maternal age at time of egg retrieval_____.

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 01/05/2020