UPMC
LIFE CHANGING MEDICINE

UPMC Pregnancy Screening Laboratory

MULTIPLE MARKER 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: ____ / ____ / _____ ☐First Sample ☐Repeat Sample

Race: _____ Weight (Lbs) _____

Is The Patient Diabetic? Yes ☐ ☐No

If Yes, Method Of Control?

☐ Insulin ☐Diet ☐ Oral Meds _____

Did Patient Have:

CVS?	☐ Yes	☐ No
First Trimester Screen?	☐ Yes	☐ No
cfDNA?	☐ Yes	☐ No
* Do You Want AFP Only?	☐ Yes	☐ No

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 5/17/2021