



Regional Pathology Services
 Human Genetics Laboratory
 985440 Nebraska Medical Center
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Quad Fetal Risk Assessment

CPT Codes: AFP-82105
 uE₃-82677
 hCG-84702
 Inhibin A-86336

All areas must be completed for specimen to be processed.

PATIENT INFORMATION

Last Name _____ First Name _____ UNH # _____
 Address _____ Phone _____ Date of Birth _____
 _____ Social Security # _____
 City State Zip

THIS INFORMATION IS NECESSARY FOR LABORATORY RESULTS

DATE SPECIMEN COLLECTED _____ Initial Specimen Repeat

ETHNIC BACKGROUND

- Caucasian American Indian
 Hispanic Asian
 African American Other _____

Gravida: G _____ P _____ AB _____

Patient's Weight _____ lbs

LMP _____ If U/S was done: _____ wks _____ days on date of U/S _____ EDC _____

Crown rump on date of U/S _____ mm _____ cm Biparietal Dia. on date of U/S _____ mm _____ cm

Is this pregnancy the result of an egg donor? Yes No Egg Donor's DOB: _____

Twin gestation? Yes No

Does the patient have insulin dependent diabetes? Yes No

Does the patient have a family history of neural tube defect? Yes No

If Yes, relationship to patient: _____

Other family history of concern: _____

REFERRED BY

Physician _____ Phone _____
 First Name Last Name

Address _____ Fax _____

UPIN# _____

BILLING INFORMATION

BILL TO: Physician / Clinic Patient / Insurance Medicaid

NOTE: SOME INSURANCE COMPANIES REQUIRE PREAUTHORIZATION. IF AUTHORIZATION IS NEEDED, PLEASE ATTACH THE REFERRAL TO THIS FORM AND SEND WITH THE SPECIMEN.

Insurance Company's name & address _____ Phone _____

ID # _____

Employer _____ Group # _____

Policy holder's name _____ Policy holder's DOB _____

NE / IA / KS / MO Medicaid # _____