

# PRENATAL and PREGNANCY LOSS Test Request Form

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## A. PATIENT IDENTIFICATION

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ MR#: \_\_\_\_\_  FEMALE  
 MALE  
 PHONE#: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ CITY/ST/ZIP: \_\_\_\_\_

## B. PREGNANCY INFORMATION

1. Was this pregnancy the result of egg donation?  No  Yes
2. Twin gestation?  No  Yes
3. Is fetal sex known?  Unknown  Female  Male
4. Does your patient want to know fetal sex?  No  Yes
5. Previous prenatal serum screen with this pregnancy?  
 No  Yes (include a copy of the report)

G: \_\_\_\_\_ P: \_\_\_\_\_ SAB: \_\_\_\_\_

### GESTATIONAL AGE

EDD: \_\_\_\_\_

GA: \_\_\_\_\_ wks \_\_\_\_\_ days - by LMP date of: \_\_\_\_\_

GA: \_\_\_\_\_ wks \_\_\_\_\_ days - on U/S date of: \_\_\_\_\_

## C. SPECIMEN DETAILS

COLLECTION DATE: \_\_\_\_\_ COLLECTION TIME: \_\_\_\_\_

PATIENT CONSENT:  Check this box if your patient does not wish to have their specimen stored. Consent is implied if box is left unchecked.

NOTES:

- Access specimen requirements at: [www.unmc.edu/geneticslab](http://www.unmc.edu/geneticslab)
- Send specimens immediately - avoid extreme temperatures.
- If necessary, store POCs refrigerated; all other samples at room temperature until shipment.
- Suboptimal specimens or those requiring cell culture may result in a longer TAT.

## D. SPECIMEN TYPE and TEST ORDERS *Indicate specimen type and select test(s).*

### PRENATAL

- Amniotic fluid
- Chorionic villus sampling (CVS)
- Fetal fluid [source]: \_\_\_\_\_
- Other specimen - [specify]: \_\_\_\_\_

### TESTING OPTIONS

- Chromosome Analysis [15-20 ml]
- FISH - Aneuploidy Screen with reflex [20 ml] » 13, 18, 21, X, Y
  - If normal - add Microarray Analysis
  - If abnormal - add Chromosome Analysis
- FISH - Aneuploidy Screen only [5 ml] » 13, 18, 21, X, Y
- FISH - 22q11.2
- FISH - Custom [specify]: \_\_\_\_\_
- Microarray Analysis with maternal cell contamination analysis [15 ml]
  - ▶ Required: maternal blood♦ [2-5 ml EDTA]
  - ♦ This is NOT chromosome analysis / karyotyping
- Microarray Analysis [15 ml]

### Non-Genetic Testing on Amniotic Fluid

performed, reported & billed by UNMC Regional Pathology Services

- AChE (acetylcholinesterase) [GA: 23 weeks or greater]
- AFAFP (amniotic fluid alpha fetoprotein) [GA: 22 weeks 6 days or less]
- CMV - PCR (cytomegalovirus)
- Parvovirus - PCR
- Toxoplasma - PCR

### PREGNANCY LOSS

#### Products of conception (POC)

- Fetal tissue [source]: \_\_\_\_\_
- Villi
- Paraffin-embedded tissue (confirmed fetal tissue) with pathology report
- Other - [specify]: \_\_\_\_\_

» RECOMMENDATION: When POC is submitted for Microarray Analysis, maternal blood♦ [2-5 ml EDTA] is requested, when available, in addition to tissue/villi to help interpret test results.

Maternal Blood included

### TESTING OPTIONS

- Chromosome Analysis with reflex to FISH for non-viable tissue
- Chromosome Analysis
- FISH - Aneuploidy Screen » 1st Trimester: 13, 16, 18, 21, 22, X, Y  
 » 2nd/3rd Trimester: 13, 18, 21, X, Y
- FISH - 22q11.2
- FISH - Custom [specify]: \_\_\_\_\_
- Microarray Analysis
  - ▶ maternal blood♦ recommended for interpretation [2-5 ml EDTA]

♦ Chromosome Analysis is NOT performed on this maternal blood.

If desired, order below and send additional blood. [2-5 ml sodium heparin]

Blood - Maternal » for chromosome analysis (karyotype)

Blood - Paternal » for chromosome analysis (karyotype)

Name/DOB: \_\_\_\_\_

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 MALE

## **E. CLINICAL INFORMATION**      ▪ SUBMIT CLINIC NOTES, if available

» Indications below are commonly associated with tests ordered on this form. They are provided as a reference and should only be used when appropriate for the testing ordered for this patient.

### PRENATAL INDICATIONS FOR TESTING:

#### • AMNIOTIC FLUID

- Abnormal prenatal screen
- Abnormal ultrasound findings (attach u/s report or specify): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Advanced maternal age, > 35 yrs of age

### OTHER INDICATION(S) / FAMILY HISTORY: (or - include clinical records, family history, pedigree)

### PREGNANCY LOSS INDICATIONS FOR TESTING:

#### • PRODUCTS OF CONCEPTION

- Intrauterine death after completion of 21 weeks gestation
- Missed abortion before completion of 20 weeks gestation
- Spontaneous abortion without completion / unspecified

## **F. BILLING**      ▪ Contact our laboratory for insurance preauthorization assistance

### INSURANCE BILLING

- ICD CODE(S): \_\_\_\_\_
- Patient Insurance » *Include a copy of card*
- Medicaid |  Medicare » *An ABN may be required*
- **Verify coverage for genetic testing and obtain / request preauthorization when required**
- Preauthorization approved
  - » Auth#: \_\_\_\_\_ Valid Date: \_\_\_\_\_ Exp Date: \_\_\_\_\_
- Preauthorization service requested (clinic notes **required**)
  - » Contact RPS Billing Support at [rpsbillingsupport@unmc.edu](mailto:rpsbillingsupport@unmc.edu)

### CLIENT BILLING


Facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/St/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### PATIENT SELF-PAY

» *View patient billing options at:*  
<http://www.reglab.org/billingcompliance/participating-insurance-plans/>

## **G. RESULT REPORTING**

### ORDERING PROVIDER:

Name: \_\_\_\_\_  
 *signature:* \_\_\_\_\_  
Facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email: \_\_\_\_\_

### ADDITIONAL REPORT TO:

Name: \_\_\_\_\_  
Facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email: \_\_\_\_\_

## **H. SHIPPING**

Shipping supplies including collection kits, tubes, transport media, and prepaid airbills are available through our supply portal.

Local Transport: Call the laboratory (402-559-6420) to request specimen pickup or utilize your routine RPS courier.

Shipping Address: UNMC Shipping & Receiving Dock  
Regional Pathology Services MSB 3500  
University of Nebraska Medical Center  
601 Saddle Creek Road  
Omaha, NE 68108-1180