University of Nebraska Medical Center
REGIONAL PATHOLOGY SERVICES

Regional Pathology Services
University of Nebraska Medical Center
981180 Nebraska Medical Center
Omaha, Nebraska 68198-1180
www.reglab.org

Toll Free: 1.800.334.0459
Phone: 402.559.6420
Fax: 402.559.9497

PRENATAL and PREGNANCY LOSS Test Request Form

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
- 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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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

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

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

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*

☐ **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 LOCATION:

Facility: _____

Client Code: _____(HGL) _____(RPS)

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Email: _____

ORDERING PROVIDER:

Name: _____

Delivery Method: _____

ADDITONAL REPORT(S) TO:

Name: _____ Name: _____

Delivery Method: _____ Delivery Method: _____

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

END OF FORM ■