Innovative BUSINESS PRODUCTS INC.

PLEASE PRINT HARD
YOU ARE MAKING 4 COPIES

Maternal Serum AFP/hCG/uE$_3$/DIA Screening Program

Section of Medical Genetics
Wake Forest University Health Sciences
Medical Center Blvd.
Winston-Salem, NC 27157-1080
www1.wfubmc.edu/medicalgenetics
Phone (336) 713-7530
Fax (336) 713-7577

PLEASE PRINT

Pt. Chart No. _____

WFUSM No. _____ / _____

TO BE COMPLETED BY THE PATIENT

SOCIAL SECURITY NO.: ___ ___ ___ — ___ ___ — ___ ___ ___ ___

PATIENT'S NAME: LAST FIRST MIDDLE MAIDEN

MAILING ADDRESS

CITY STATE ZIP CODE

HOME PHONE ( )

WORK PHONE ( )

DATE OF BIRTH / /

AGE

RACE:

☐ White ☐ American Indian/Alaskan ☐ Hispanic

☐ Black ☐ Asian/Pacific Islander ☐ Other

Does anyone in YOUR family or your partner's family have a NEURAL TUBE DEFECT (open back, open skull)? ☐ Yes ☐ No

If "Yes," how is that person related to you and what is the defect?

_____

_____

☐ Nonsmoker ☐ Smoker _____ #cigarettes/day

TO BE COMPLETED BY HEALTH CARE PROVIDER

PATIENT'S WEIGHT lbs.

DATE SAMPLE WAS DRAWN / /

PHYSICIAN'S NAME (FIRST, LAST)

WFUSM USE ONLY

CLINIC NAME

PHONE NUMBER ( )

☐ 1st Sample ☐ 2nd Sample ☐ 3rd Sample

Please Provide Only ONE Gestational Dating

___/___/___ LMP ___/___/___ EDD

___/___/___ LMP by ultrasound ___/___/___ EDD by ultrasound

___/___/___ EDD by exam

Is this patient an insulin dependent diabetic? ..... ☐ Yes ☐ No

Is this a known twin pregnancy? ..... ☐ Yes ☐ No

By submitting a sample, you are ordering a quad marker screen for open neural tube defects, Down syndrome and Trisomy 18. If you require only a single marker (AFP only) screen, please explain:

_____

I have been informed of the purpose of having my blood drawn and analyzed for maternal serum screening. I understand that this blood test will not identify all babies with a neural tube defect, Down syndrome or Trisomy 18. I understand that a positive test does not necessarily mean that my baby has one of these conditions and that a positive test requires other tests before a diagnosis can be made. I also understand that this test will not identify all chromosome abnormalities, birth defects, and/or other forms of mental retardation. I authorize the staff of the MSAFP/hCG/uE$_3$/DIA Screening Program to review and copy my medical records for documentation of results and for pregnancy outcome information, if necessary.

X _____ _____

PATIENT'S SIGNATURE DATE

ACCOUNT GUARANTOR INFORMATION - Where to Mail Statement, Person Reponsible for Bill

GUARANTOR LAST NAME FIRST NAME MIDDLE INITIAL HOME PHONE ( )

STREET ADDRESS CITY STATE ZIP CODE

GUARANTOR'S EMPLOYER WORK PHONE ( )

PATIENT'S INSURANCE COVERAGE INFORMATION

PATIENT **MEDICAID** RECIPIENT I.D. NO. CAROLINA ACCESS NO. PROVIDER NAME VALID FROM / / TO / /

GROUP INSURANCE COVERING PATIENT SUBSCRIBER I.D. NO. GROUP NO.

ADDRESS TO MAIL CLAIM TO CITY STATE ZIP CODE

POLICY HOLDER NAME - SUBSCRIBER EFFECTIVE DATE / / EXPIRATION DATE / / RELATIONSHIP TO PATIENT

MEDICARE CLAIM NO. HOSPITAL INSURANCE ☐ Yes ☐ No EFFECTIVE DATE / / MEDICAL NO. ☐ Yes ☐ No EFFECTIVE DATE / /

I authorize any holder of medical or other information about me to release to my insurance carrier, the health care financing administration or its intermediaries or carriers any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of authorized insurance benefits be made on my behalf to Wake Forest University Physicians or to myself if assignment is not accepted.

X _____ _____

PATIENT'S SIGNATURE DATE