DEPARTMENT OF MEDICAL GENETICS

Henry Ford Hospital
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Maternal Serum Screening (MSAFP)

Requesting Care Provider:_____ provider code: _____

SELECT DESIRED TEST: diagnostic code(ICD-9) _____

☐ **FIRST TRIMESTER SCREEN:** Result in First Trimester
PAPP-A , hCG, and Nuchal Translucency (NT)
ultrasound measurement required *
Between 11 0/7 to 13 6/7 weeks [No neural tube evaluation available from this test.]

MSAFP – INTEGRATED SCREEN: 2 step test
Result after the second sample received. No First trimester result.
FULL Integrated = 1st & 2nd trimester blood samples & NT measurement
SERUM Integrated = 1st & 2nd trimester blood samples only

☐ **STEP ONE: PAPP-A** (with or without **NT***)
Between 10 0/7 to 13 6/7 weeks

☐ **STEP TWO: Quad screen**
Between 15 0/7 to 22 6/7 weeks

SEQUENTIAL or *Blended* SCREENING: 2 step test
First Trimester result if high risk, otherwise proceed to addition of second sample

☐ **STEP ONE: PAPP-A, hCG, NT** required*
Between 11 0/7 to 13 6/7 weeks

☐ **STEP TWO: Quad screen**
Between 15 0/7 to 22 6/7 weeks

☐ **MSAFP – QUAD SCREEN** Between 15 0/7 to 22 6/7 weeks
MSAFP, uE3, hCG, and InhibinA in second trimester

☐ **MSAFP – TRIPLE TEST** Between 15 0/7 to 22 6/7 weeks
MSAFP, uE3, and hCG in second trimester

☐ **MSAFP ONLY: for neural tube assessment.**
Select for patients who have had: FIRST TRIMESTER screen,
CVS (Chorionic Villus sampling), or prior Down syndrome only screen
Between 15 0/7 to 22 6/7 weeks [*cannot interpret if drawn before 15 0/7 weeks*]

- ***Sample requirements: 1 SERUM SEPARATOR TUBE***

* Samples received without the required Nuchal Translucency (NT) data will be "reflexed" to serum Integrated test components.

Ultrasound: **Date of scan**_____/_____/_____
Number of Fetuses* ☐ one ☐ two

	Baby 1	Baby 2
Crown Rump Length	_____mm	_____mm
Or		
Biparietal Diameter	_____mm	_____mm
Gestation	_____weeks _____days	_____weeks_____days
Nuchal translucency (NT)	_____mm	_____mm

Sonographer _____
Sonographer must be a pre-arranged participant with HFH program to use the NT measurement

(* no interpretation for pregnancies with more than 2 fetuses)

Date of sample _____/_____/_____

MRN

Last Name_____

First Name_____

Maiden Name_____

Address_____

City_____

State_____ Zip Code_____

Patient's phone number (_____)_____

Pregnancy information: LMP _____/_____/_____
LMP date: Certain ☐ **Uncertain** ☐
If LMP is not known and ultrasound dating is not available, please provide physical exam dating
_____weeks on _____/____/_____ (date of physical exam)

Patient weight_____pounds **Date of Birth**____/____/____

Patient race_____

- ☐ **yes** ☐ **no** **Patient has had FIRST Trimester screening.**
- ☐ **yes** ☐ **no** **Patient had CVS or Amniocentesis during THIS pregnancy**
- ☐ **yes** ☐ **no** **Patient has medication-dependant diabetes at conception.**
- ☐ **yes** ☐ **no** **Patient smokes cigarettes.**
- ☐ **yes** ☐ **no** **Patient had a prior pregnancy with Down syndrome.**
- ☐ **yes** ☐ **no** **Patient had a prior pregnancy with a neural tube defect.**
- ☐ **yes** ☐ **no** **This is an In Vitro Fertilization pregnancy.**
- ☐ **yes** ☐ **no** **Donor egg was used. Age of donor_____ years**
- ☐ **yes** ☐ **no** **This is a repeat sample.**

Care Provider Name and Address for report:

(_____)_____(_____)_____
Telephone number Fax number

For Lab Use

INSURANCE INFORMATION: please provide information from insurance card ***(attach copy of front and back of card for best results)***

____Blue Cross/Blue Shield
____ Medicaid
____ HAP
____ Tricare
____ Commercial /Other
Specify:_____

** **NOTE: SOME INSURANCE PLANS MAY REQUIRE AN AUTHORIZATION TO HFH FOR PAYMENT OF TESTING**

Subscriber:_____
Relationship to patient:_____
Subscriber Date of Birth:_____/_____/_____

Group:_____
ID:_____
Group Name:_____
Program:_____
Effective date:_____/_____/_____

Tricare/Military coverage:
Sponsor:_____
Organization:_____
Relationship to patient:_____
Rank/Grade:_____
Station:_____
ID Card number:_____
Effective date:_____/_____/_____
Dependant:_____
Status: