HIGHLIGHTED FIELDS REQUIRE DOCUMENTATION

MARQUETTE GENERAL
A Duke LifePoint Hospital
420 W. Magnetic St, Marquette MI 49855
906-225-3050 1-888-818-3879

INTEGRATED SERUM FORM

Patient Information:

Name: Last

First MI Phone

Address:

City State Zip

Birthdate: Weight:

Race: ☐ African American ☐ Caucasian (Non-Hispanic)
☐ Asian/Pacific Islander ☐ Native American
☐ Hispanic ☐ _____:Other

Gestational Age: _____: Wks ____: Days

On date ____/____/___: By: ☐ LMP ☐ EDC/EDD ☐ U/S

☐ Yes ☐ No Is patient an insulin dependent diabetic?

# of Fetuses: ☐ 1 ☐ 2 ☐ _____: Other

☐ Yes ☐ No Egg donor: ☐ Self ☐ Non-self
Age of donor at egg retrieval: ____years

☐ Yes ☐ No Prior Down Syndrome/ONTD Screen in Current Pregnancy?
If Yes, prior test was:
☐ in 1st Tri ☐ in 2nd Tri ☐ elevated msAFP

Maternal Serum Screening w/o Int

☐ Serum Integrated 1 (10-13 weeks)
☐ Serum Integrated 2 (15-21 weeks)

Ordering Information: (Requisition Required with Form)

Clinical History

☐ Yes ☐ No Prior Down Syndrome/ONTD Screen in Current Pregnancy?
If Yes, prior test was:
☐ in 1st Tri ☐ in 2nd Tri ☐ elevated msAFP

☐ Yes ☐ No Family History of NTD?

☐ Yes ☐ No Previous pregnancy with Down Syndrome?

☐ Yes ☐ No Indications:

Diagnosis: (ICD9 format) required for each test billed to patient

1 3

2 4

Requesting Physician:

Additional Copy: Authorized Signature: Date: Time:

Website: **WWW.MGHLAB.COM**