

# Laboratory Services

AFP REQUISITION (04/07)

CUSTOMER SERVICE PHONE: (847) 663-2100

FAX REPORT TO: \_\_\_\_\_

PATIENT LAST NAME		FIRST NAME		ENHLS CHARGES BILLED TO:			
PATIENT SSN (NOT GUARANTOR)		DATE OF BIRTH		SEX		<input type="checkbox"/> Physician Office (ENHLS Client)	
STREET ADDRESS				<input type="checkbox"/> Medicare (Include letter): _____ <input type="checkbox"/> Insurance (Complete insurance section below)			
CITY				STATE		ZIP CODE	
TELEPHONE				PATIENT CHART/CLIENT SPEC NO.		DATE/TIME COLLECTED	
INSURANCE CO NAME & ADDRESS				PLAN/GROUP:			
				NAME OF INSURED:			
ICD-9 Code(s)		1)		2)		3)	
						4)	

**TEST REQUESTED** (check ONE only):

**AFP Triple Screen (Test # 4299)**  
(Performed Inhouse- Replaces 4 Marker Screen)

**AFP-Maternal Serum (Test # 4944)**  
(ONTD only – does not include Down Syndrome Screen)

Date Of Sample Draw: \_\_\_\_\_

**DATA FOR CORRECTION FACTORS:**

Weight: \_\_\_\_\_ (lb)      Race: W B O      Insulin Dependent Diabetic: Y N

Multiple Pregnancy (twins, triplets, etc.): Y N      # fetuses: \_\_\_\_\_

Is this the first MSAFP screening test for this pregnancy? Y N  
If no, what is date of previous test? \_\_\_\_\_

Is there a donor egg mother?  yes  no    If yes, what is donor egg mother's AGE? \_\_\_\_\_ years

GA by: (circle ONE)	Ultrasound	LMP	Physical Exam	EDC/EDD
Date:	*		**	
GA (Weeks-days)				

Notes:

- Please complete information for **ONE GA** choice only.
  - \* For US (Ultrasound) provide date of ultrasound & GA on that date. (Computer will automatically compute GA to draw date on final report.)
  - \*\* For PE (Physical Exam) provide date of physical exam and GA on that date. (Computer will automatically compute GA to draw date on final report.)
  - **This laboratory has normal ranges for 15 weeks through 20 weeks 6 days GA.**
- GA = Gestational Age  
LMP = Last Menstrual Period  
EDC/EDD = Estimated Date of Confinement/Estimated Date of Delivery