SHODAIR CHILDREN'S HOSPITAL GENETICS LABORATORY
2755 Colonial Dr, Helena. MT, 59601 (406) 444-7532 (800) 447-6614
Fax (406) 444-1022, Email: mtgene@shodair.org

SHODAIR LAB #:

FETAL STUDIES REQUEST FORM (*Please send this completed form with the specimen*)

MOTHER: LAST NAME ____________________________ **FIRST NAME**_______________________________ **DOB**___________________

FATHER: LAST NAME ____________________________ **FIRST NAME**_______________________________ **DOB**___________________

Fetus Gender M / F **DATE & TIME OF DELIVERY:**____________________ **Optional: Fetus Name:**___________________

REF. LAB #: ___________________ **DATE COLLECTED:**________________ **DATE RECEIVED:** __________________

ETHNIC BACKGROUND: (Circle all that apply) European Caucasian, Hispanic, Native American, African American, Asian, Other

REFERRING PHYSICIAN/ HEALTH PROFESSIONAL:
Name: ____
Address: ____
City, State, Zip: ____________________________________
Telephone:(_____)____________FAX:(_____)____________

PRIMARY CARE PHYSICIAN: _________________________________
REFERRING INSTITUTION / CLINIC / LABORATORY:
Name: ____
ADDITIONAL REPORTS TO:
Name: ____

PHYSICIAN SIGNATURE: **Date:**
(required for Medicare / Medicaid billing)

BILLING INFORMATION:
❑ **REFERRING INSTITUTION**

New clients please call laboratory with financial contact information.

❑ **INSURANCE**
Name of policy holder:___________________________
Policy holder DOB:______________________________
SS # (Guarantor): ______________________________
Address:_______________________________________
Phone #:_____________________________________
Relationship to patient:__________________________
Insurance Co. / Policy #:_________________________
Insurance Co Contact / Phone #:_________________

❑ **Medicaid #:**______________
State (MT, ID WY): ___________
SS#:________________________

❑ **SELF PAY**

❑ **Inpatient**

CLINICAL INFORMATION

GRAVIDA:_____ **PARA:**_____ **Spontaneous Abortions:**_____ **Therapeutic Abortions:**_____ **MOLAR: Yes**___ **No**___ **Stillbirths:**___

PRESENT PREGNANCY **LMP:** ______________ **Pregnancy weeks by U/S:** _______________ **Date of U/S:** __________________

FAMILY HISTORY	YES	NO	SPECIFY
Repeated miscarriages	____	____	__________________
Stillbirth	____	____	__________________
Malformed	____	____	__________________
Mental retardation	____	____	__________________
Other	____	____	__________________

MATERNAL SERLOGICAL ESTS:	POSITIVE	NEGATIVE	TITER/SPECIFY
Toxoplasmosis	____	____	__________________
Syphilis	____	____	__________________
Rubella	____	____	__________________
CMV	____	____	__________________
Herpes	____	____	__________________
Coombs	____	____	__________________
Others (Specify)	____	____	__________________

PRESENT PREGNANCY	YES	NO	SPECIFY
Threatened abortion	____	____	__________________
Oligo/polyhydramnios	____	____	__________________
Diabetes	____	____	__________________
Pre-eclampsia/eclampsia	____	____	__________________
Hypertension	____	____	__________________
Alcohol	____	____	__________________
Drugs	____	____	__________________
Cigarettes	____	____	__________________
X-rays	____	____	__________________
Other exposures	____	____	__________________
Prenatal diagnosis	____	____	__________________
Illnesses/operations	____	____	__________________
Consanguinity	____	____	__________________
At risk serum screen	____	____	__________________

Other:____

SPECIMEN TYPE: (Please circle) PLEASE NOTIFY THE LABORATORY WHEN A SPECIMEN IS BEING SENT. 1-800-447-6614, EXT. 7532

❑ **Fresh tissue:** ☐ **POC** ☐ **fetal** ☐ **other (specify source):** ______________

TEST REQUESTED: (Please check one or more; test descriptions with CPT codes and prices faxed on request).

❑ **Limited Fetal Pathology (external exam)** ❑ **Cytogenetics** ❑ **Other:**_____________________

Date Set Up: ________________	**Med. Rec. #**__________________	**Admit #**______________________	**Shire #**_____________________

PLEASE CALL LAB @ (406)444-7532 WITH SHIPPING DETAILS.