F 03 088 058 3 B

FIRST TRIMESTER SCREENING

10 WEEKS 0 DAYS TO 13 WEEKS 6 DAYS

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

CALIFORNIA PRENATAL SCREENING PROGRAM

(866) 718-7915 Toll Free

ACCESSION LABEL
FOR STATE LAB USE ONLY
DO NOT COVER

PART A: PLEASE WRITE CLEARLY. USE CAPITAL LETTERS.

1. PATIENT INFORMATION

LAST NAME LAST NAME | FIRST NAME FIRST NAME | MAIDEN NAME MAIDEN NAME

ADDRESS STREET ADDRESS APT

CITY ST ZIP | MEDICAL REC. NO. MEDICAL RECORD#

BIRTH DATE MM-DD-YY | SSN SSN- - | PHONE NUMBER PHONE- -

2. RACE/ETHNICITY (mark all that apply up to four races)

☐ WHITE ☐ NATIVE AMERICAN ☐ JAPANESE ☐ SAMOAN ☐ CAMBODIAN ☐ MIDDLE EASTERN ☐ OTHER
☐ BLACK ☐ HAWAIIAN ☐ KOREAN ☐ FILIPINO ☐ LAOS ☐ INDIAN SUBCONTINENT ☐ UNKNOWN
☐ HISPANIC/LATINA ☐ CHINESE ☐ GUAMANIAN ☐ VIETNAMESE ☐ OTHER SOUTHEAST ASIAN

3. BILLING INFORMATION

PATIENT'S MEDI-CAL #, BIC, OR PE #

PNS BILLING CODE

4. PATIENT'S/AUTHORIZED PERSON'S SIGNATURE FOR INSURANCE OR MEDI-CAL BILLING

I authorize the release of any medical or other information necessary to process an insurance claim and assign payment of medical benefits to the California Department of Public Health, Genetic Disease Screening Program for services rendered. I understand and agree that I am ultimately responsible for payment.

X

Signature of Patient/Insured/Authorized Person | Date

5. CLINICIAN TO BE NOTIFIED OF PATIENT'S RESULTS

LICENSE# OR NPI # | LAST NAME LAST NAME | FIRST NAME FIRST NAME

FACILITY FACILITY NAME | PHONE NUMBER PHONE- - EXT

ADDRESS STREET ADDRESS SUITE | FAX FAX- - -

CITY ST ZIP

6. PREGNANCY DATING: IF NO NT, ULTRASOUND PREFERRED. IF NO NT OR ULTRASOUND, PROVIDE EITHER LMP OR EXAM (not both).

ULTRASOUND DATE PERFORMED (MONTH DAY YEAR)	GESTATIONAL AGE ON DATE OF ULTRASOUND (WEEKS AND DAYS)	OR DECIMAL WEEKS	LMP - FIRST DAY OF LAST NORMAL MENSTRUAL PERIOD (MONTH DAY YEAR)	DATE OF MOST RECENT PHYSICAL EXAM (MONTH DAY YEAR)	UTERINE SIZE IN WEEKS
MM-DD-YY			MM-DD-YY	MM-DD-YY	

7. NUMBER OF FETUSES IN THIS PREGNANCY

1 (ONE) ☐ 2 (TWINS) ☐ (UNKNOWN) ☐

8. PATIENT'S MOST RECENT WEIGHT

LBS OR KILOS

9. IS PATIENT INSULIN-DEPENDENT DIABETIC (prior to pregnancy)?

☐ YES ☐ NO

10. WAS THERE AN OVUM DONOR FOR THIS PREGNANCY?

☐ YES ☐ NO If yes, age of donor at time of donation. Years

11. HAS PATIENT SMOKED CIGARETTES IN THE LAST 7 DAYS?

☐ YES ☐ NO

12. NUCHAL TRANSLUCENCY INFORMATION

NT PRACTITIONER CRED # | NT SUP CRED# (optional)

NT SITE CODE (optional) | NT EXAM DATE MM-DD-YY

CRL (FETUS A) mm | UNABLE TO MEASURE CRL ☐

NT (FETUS A) mm | UNABLE TO MEASURE NT ☐

TWIN PREGNANCY? ☐ YES ☐ NO

CHORIONICITY FOR TWINS
☐ MONOCHORIONIC
☐ DICHORIONIC
☐ UNABLE TO DETERMINE

CRL (FETUS B) mm | UNABLE TO MEASURE CRL ☐

NT (FETUS B) mm | UNABLE TO MEASURE NT ☐

13. PATIENT CONSENT FROM BOOKLET:

IF PATIENT MARKED "I DECLINE THE USE OF MY SPECIMEN FOR RESEARCH" ON THE CONSENT FORM, FILL IN THE BOX AT RIGHT. ☐ PATIENT DECLINED RESEARCH ON CONSENT FORM.

PART B: MUST BE COMPLETED AT TIME OF SPECIMEN COLLECTION. SEE COVER FOR COLLECTION AND MAILING INSTRUCTIONS.

COLLECTION DATE IS MANDATORY!

BLOOD SPECIMEN COLLECTED ON: MM-DD-YY

FACILITY WHERE BLOOD COLLECTED

COLLECTOR'S INITIALS

TELEPHONE PHONE- -

14. THIS FORM COMPLETED BY (please print name)

ADDRESSOGRAPH

CDPH 4092 (11/10)

DISTRIBUTION: WHITE ORIGINAL MUST ACCOMPANY SPECIMEN.

ENCLOSE A COPY OF **INSURANCE CARD** OR PROVIDE **MEDI-CAL NUMBER** IN #3 ABOVE TO ALLOW CORRECT BILLING.