Western Maryland Health System
12500 Willowbrook Rd, SE, Cumberland, MD 21502
Phone: 240-964-2522 Fax: 240-964-2525

PRENATAL-OB GYN REQUISITION

Collected By

Date Collected

Time Collected

PATIENT NAME LAST	FIRST	M.I.	REQUESTING PHYSICIAN (Please Print)

SEX	RACE	BIRTH DATE : MO. DAY YEAR	SOCIAL SECURITY NUMBER (LAST 4 DIGITS)	REQUESTING PHYSICIAN SIGNATURE and DATE
			xxx-xx-	

BILLING INFORMATION: BILL TO: CLIENT , PATIENT - (COMPLETE SECTION A) , INSURANCE - (COMPLETE SECTION B and C)

Section A	STREET ADDRESS CITY STATE ZIP		TELEPHONE NO.
Primary Insurance Section B	NAME OF INSURANCE COMPANY	Secondary Insurance Section C	NAME OF INSURANCE COMPANY
	INSURANCE NO-POLICY / GROUP		INSURANCE NO-POLICY / GROUP

PHYSICIAN DIAGNOSIS REQUIREMENT NOTICE

When ordering tests, please be informed that the physician (or other authorized individual) is required to make an independent medical necessity decision with regard to each test the laboratory will bill. Additionally, the physician (or other authorized individual) understands he or she is required to submit narrative diagnosis information, supported by the patient's medical record. When medical necessity requirements are not met, an ABN must be completed to inform the patient they may be responsible for payment. Obtain a signed ABN for tests with defined frequency limits.

NARRATIVE DIAGNOSIS or SYMPTOM :

	PRENATAL PANEL 80055				
	Group & Rh (ABORH)		Group & Rh (ABORH) 86901		Estradiol 82670
	Irregular Antibody Screen (ABS)		Antibody Screen (ABS) 86850		Progesterone 84144
	RPR		CBC/Autodiff 85025		Ureaplasma/Mycoplasma 87081
	Rubella		RPR 86592		*(Random urine in transport media)*
	CBC/AutoDiff (if flag,Man Diff at no charge		Rubella 82762		Maternal AFP 82105
	HbsAg		Glucose Post 50 gm Glucola 82950		***(Must have separate form)***
	Cystic Fibrosis (CFDNA) 83901		3Hr Gestational GTT 82951,82952		TriScreen 82105,
	83891,83909,83914,83900,83912		Glucose Fasting 82947		***(Must have separate form)*** 82677,84702
	Sickle Cell (Hgb Electrophoresis will be		Glucose PP 82947		Quadscreen 82105,82677,84702,86336
	Performed. 83021		HCG Qualitative 84703		**(Must have separate form)**
	TSH 84443		HCG Quantitative 84702		HIV 1, 2 Antibody. If Reactive, confirmation
	Urinalysis Routine 80001		Toxoplasmosis Tot Atb (IgG/IgM) 86777x2		performed at additional charge. 86703
	(Dipstick & Microscopic)		A1C, Hemoglobin 83036		_____PATIENT COUNSELED **(Requirement)**
	Urine Dipstick only 81003		CMV (Cytomegalovirus (IgM) Atb) 86645		
	Urine MIcroscopic only 81015		Rh Titer 86886		
	Urine Culture 87086		Rhogam at 28 weeks*		
	Urine Drug Abuse (DABS) 80101x8		Rhogam Injection		

***Note:** **Rhogam at 28 wks patients should make arrangements with the Emergency Dept for the administration of the RhoGam on the day their blood is drawn.**

Culture/DNA Testing - *Please submit separate requisitions if more than one site is cultured.*

Must record Source/Site on line

_____ Group B (GEN-OB) 87653 - **Penicillin Allergy?** _____

_____ R/O Pathogens *** 87070 _____

_____ Urine Culture 87086

Must check specific Source/Site

_____ Chlamydia DNA Probe (CHDNA) 87490 _____Cervix ____Urethra _____ Vagina
(Requires collection in Male or Female Gen-Probe Kit

_____ GC DNA Probe (GCDNA) 87490 _____Cervix ____Urethra _____Vagina _____ Urine
(Requires collection in Male or Female Gen-Probe Kit

_____ Yeast DNA Probe 87480

_____ Trichomonas DNA Probe 87660

_____ Gardnerella DNA Probe 87797

***includes R/O GC cultures of the cervix, vagina or urethra**

Master Requisitions
FORM #0027902 Rev 10/28/09