In order to process your testing request, the following must be answered completely. This information is required by Quest Diagnostics to result patient testing for **StepWise 2**

|  |  |
| --- | --- |
| PHYSICIAN NAME |   |
| PHYSICIAN PHONE |   |
| PHYSICIAN NPI |   |
| PATIENT DOB |   |
| COLLECTION DATE |   |
| MATERNAL WEIGHT |   |
| ESTIMATED DATE OF DELIVERY |   |
| **MOTHER'S ETHNIC ORIGIN** |   |
|  AFRICAN AMERICAN |   |
|  ASIAN |   |
|  CAUCASIAN |   |
|  HISPANIC |   |
|  OTHER |   |
| **SPECIMEN # FROM PART 1** |   |
| ULTRASOUND DATE |   |
| CROWN RUMP LENGTH |   |
| NUCHAL TRANSLUCENCY |   |
| **NASAL BONE** |   |
|  PRESENT |   |
|  ABSENT |   |
|  NOT ASSESSED |   |
| IF TWINS |   |
| TWIN B CROWN RUMP LENGTH |   |
| TWIN B NASAL BONE |   |

Please fax completed questionnaire to: 219-989-3770, Attn: Reference