MSAFP

Consent & Order Form

Gestational Age Range: 15 Weeks 0 Days - 21 Weeks 0 Days

CDPH
For state lab use only

Blue/black ink | * = required | MM/DD/YYYY date format | Fill boxes completely | A Capital Letters

1. Patient Information

Last Name* | First Name* | Int. | Maiden Name

Biological Date of Birth* (M M / D D / Y Y Y Y) | Social Security # (- -) | Medical Record # | Most Recent Weight* (.) ☐ lbs ☐ kg

Race and Ethnicity* (Select up to 4 that apply or "Unknown")

- ☐ Black
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian
- ☐ Hawaiian
- ☐ Japanese
- ☐ Korean
- ☐ Lao
- ☐ Latinx/Hispanic
- ☐ Middle Eastern
- ☐ Native American
- ☐ Samoan
- ☐ South Asian
- ☐ Other Southeast Asian
- ☐ Vietnamese
- ☐ White
- ☐ Other
- ☐ Unknown

Patient currently diabetic?* ☐ Yes ☐ No

Does patient take insulin? ☐ Yes ☐ No ☐ Unknown

Patient Street Address* (for medical/confidential mail) | Address Line 2 (APT, STE, UNIT, etc.)

City* | State* | ZIP Code* | Patient Phone #* (- -)

2. Pregnancy Information

Number of Fetuses* ☐ 1 ☐ 2

Dating Method* (Complete only one Dating Method. Ultrasound is best. If no U/S, provide LMP)

☐ Ultrasound — Ultrasound Date Performed (M M / D D / Y Y Y Y) | GA on Ultrasound Date ☐☐ Weeks ☐ Days | CRL (Fetus 1) ☐☐.☐ mm | CRL (Fetus 2) ☐☐.☐ mm

☐ LMP — First Day of Normal LMP (M M / D D / Y Y Y Y)

☐ Physical Exam — Most Recent Physical Exam Date (M M / D D / Y Y Y Y) | Uterine Size ☐☐ Weeks

3. Clinician & Facility Information (Clinician must be a licensed medical professional)

Last Name* | First Name*

Medical License Type* ☐ MD ☐ DO ☐ PA ☐ NP ☐ CNM ☐ Other

Medical License #* | NPI #*

Facility Name* | Facility Phone #* (- -) | PNS Billing Code

Facility Street Address* | Address Line 2 (BLDG, FL, STE, etc.)

City* | State* | ZIP Code* | Facility Fax # (- -)

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Patient Last Name*

Patient Date of Birth* MM / DD / YYYY

Name of Person Completing Form*

4. Billing Information

Bill To* (Choose one, to allow for correct billing, provide Medi-Cal or other insurance information.)

☐ Insurance ☐ Medi-Cal ☐ Self Pay

Policy or Medi-Cal #

Group ID

Insurance Provider Name

Relationship to Insured (If patient is not the primary insured, provide insured details which are required for billing.)

☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Last Name

Insured First Name

Insured Date of Birth MM / DD / YYYY

Insured Sex ☐ Female ☐ Male

Insured Phone # ___ - ___ - ____

5. Patient Consent

If you give consent to prenatal screening by signing below, your blood will be collected and sent to a state-contracted laboratory for prenatal screening.

- *I consent to participate in the California Prenatal Screening Program.*
- *I authorize the release of medical and any other information about myself needed for my health insurance claim.*
- *I authorize payment of medical benefits to the Genetic Disease Screening Program (GDSP) for services provided to me.*
- *I consent to be billed directly for the services provided to me if I do not have health insurance coverage or Medi-Cal.*
- *I agree my blood sample may be used for research by GDSP or GDSP-approved researchers, unless the box below is marked.*

☐ *I decline the use of my specimen for research.*

Date* MM / DD / YYYY

X _____

Signature of Patient/Authorized Person*

☐ *Check here and complete below if patient consent was obtained:*

Provider/Representative Name

Relationship to Patient

6. Blood Sample

Blood Draw Facility Name*

NAPS Lab Notes

Blood Draw Date* MM / DD / YYYY

Collector's Initials*

Blood Draw Facility Phone #* ___ - ___ - ____