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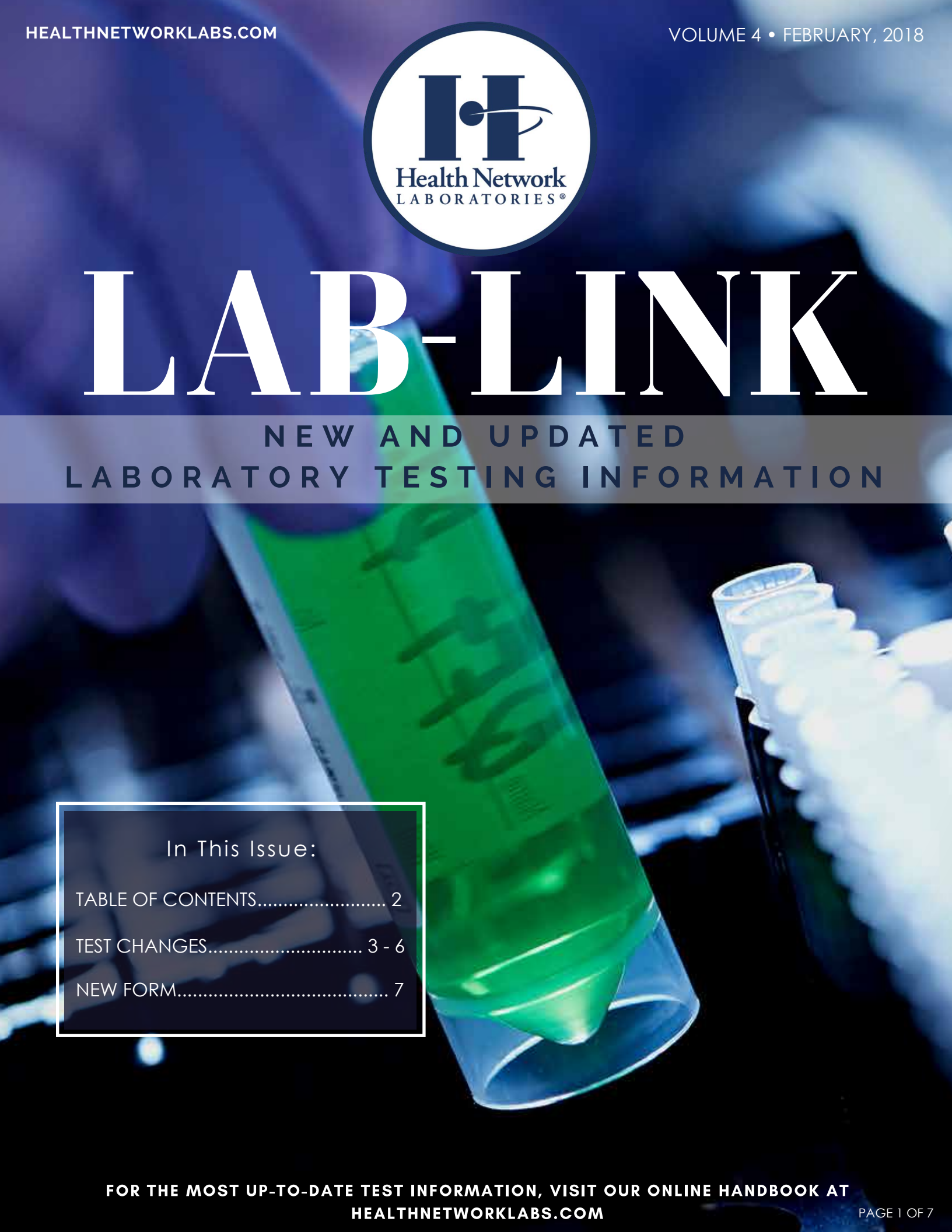
Health Network LABORATORIES®

LAB-LINK

NEW AND UPDATED LABORATORY TESTING INFORMATION

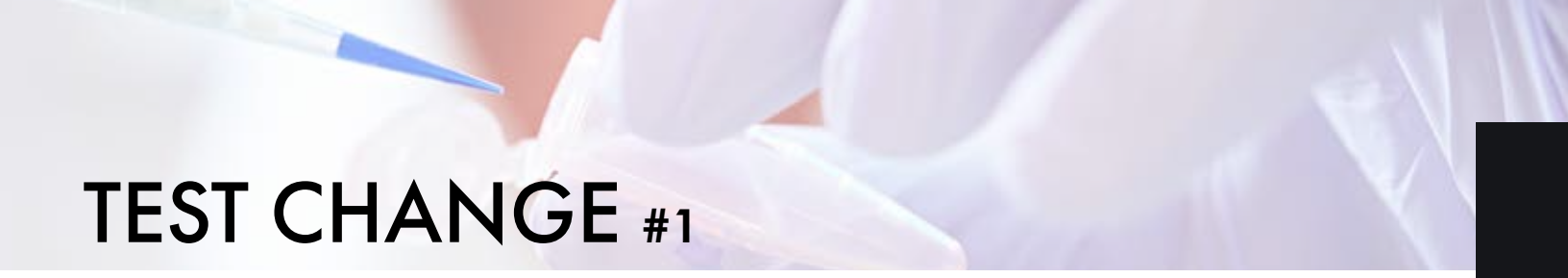


In This Issue:

FOR THE MOST UP-TO-DATE TEST INFORMATION, VISIT OUR ONLINE HANDBOOK AT HEALTHNETWORKLABS.COM

TEST NAME/SUBJECT	EFFECTIVE DATE	PAGE
TEST CHANGE #1		
• HEMOGLOBIN, WHOLE BLOOD (HGB)	02/20/2018	03
TEST CHANGE #2		
• GLUCOSE, SERUM OR PLASMA (GLUC)	02/20/2018	04
TEST CHANGE #3		
• MATERNAL SERUM TESTING	02/20/2018	05-06
New Patient History for Maternal Serum Testing		*(see page 7)*

AS YOUR LABORATORY PARTNER, HEALTH NETWORK LABORATORIES IS PLEASED TO KEEP YOU CONNECTED TO NEW AND UPDATED LABORATORY TESTING INFORMATION.



TEST CHANGE #1

The following test change will be effective on the date indicated below. Please note that the changes are listed in bold, italicized and highlighted type. Additional information regarding the change will be provided where applicable.

Hemoglobin, Whole Blood (HGB)	
Description of Change:	***Critical value change from <8.0 g/dL to <7.0 g/dL for HGB on patients >60 days.***
Effective Date:	02/20/2018
Suggested CPT Code:	85018
Methodology:	Automated Analyzer
Testing Schedule:	Routine daily, STAT testing available
Report Availability:	1 day
Specimen Requirements:	MINIMUM VOLUME: • 1.5 mL whole blood OR 300-500 µL in BD Microtainer™ tube CONTAINER: • Lavender top tube, EDTA
Clinical Utility:	Used in the evaluation of anemias,polycythemias, blood loss and hemolysis.

Reference Range:

Age	Reference Range
0-3 days:	15.6-20.2 g/dL
4-7 days:	16.4-18.0 g/dL
8-28 days:	15.0-17.1 g/dL
1 month:	13.0-15.0 g/dL
2 months:	10.0-12.4 g/dL
3 months:	9.9-14.5 g/dL
6 months:	9.5-14.1 g/dL
1 year:	8.9-13.5 g/dL
2 years:	9.2-13.8 g/dL
3 years:	10.2-14.8 g/dL
4 – 5 years:	10.3-14.9 g/dL
6-10 years:	10.6-15.2 g/dL
11 years:	11.1-15.7 g/dL
15 yrs. – female:	12.0-16.0 g/dL
15 yrs. – male:	13.5-18.0 g/dL
21 yrs. – female:	11.5-14.5 g/dL
21 yrs. – male:	12.5-17.0 g/dL

Critical Values:

≤ 3 days:	< 12.0 g/dL or > 22.0 g/dL
4-60 days:	< 9.0 g/dL or > 20.0 g/dL
> 60 days:	***< 7.0 g/dL or > 21.0 g/dL***

For more information, please contact Diane Raber at 877-402-4221.

TEST CHANGE #2

The following test change will be effective on the date indicated below. Please note that the changes are listed in bold, italicized and highlighted type. Additional information regarding the change will be provided where applicable.

<table>
<tr><th colspan="2">Glucose, Serum or Plasma (GLUC)</th></tr>
<tr><td>Description of Change:</td><td>Change in glucose low critical value
NOTE: THIS CRITICAL VALUE CHANGE EFFECTS <u>ALL</u> GLUCOSE TESTS</td></tr>
<tr><td>Effective Date:</td><td>02/20/2018</td></tr>
<tr><td>Suggested CPT Code:</td><td>82947</td></tr>
<tr><td>Methodology:</td><td>Endpoint</td></tr>
<tr><td>Testing Schedule:</td><td>Routine daily, STAT testing available</td></tr>
<tr><td>Report Availability:</td><td>1 day</td></tr>
<tr><td>Specimen Requirements:</td><td>MINIMUM VOLUME:
• 1 mL serum or plasma
CONTAINER:
• Gold top tube, serum separator or Light Green top tube, plasma separator
COLLECTION:
• Overnight fasting preferred</td></tr>
<tr><td>Clinical Utility:</td><td>Used in the evaluation of carbohydrate metabolism.</td></tr>
<tr><td>Reference Range:</td><td>
<table>
<tr><td colspan="2">Fasting:</td></tr>
<tr><td>< 7 days:</td><td>47-110 mg/dL</td></tr>
<tr><td>= 7 days:</td><td>65-99 mg/dL</td></tr>
</table>
NOTE: American Diabetes Association, Fasting Glucose Reference Range recommendation:
<table>
<tr><td>Normal:</td><td>65-99 mg/dL</td></tr>
<tr><td>Impaired:</td><td>100-125 mg/dL</td></tr>
<tr><td>Diagnostic for Diabetes mellitus:</td><td>>125 mg/dL</td></tr>
<tr><td>Target for Diabetes mellitus:</td><td>90-130 mg/dL</td></tr>
</table>
</td></tr>
<tr><td>Critical Values:</td><td>• < 50 mg/dL
• > 400 mg/dL
(All glucose low critical values are changing from < 40 mg/dL to <50 mg/dL.)</td></tr>
</table>

For more information, please contact Charlene Miller at 877-402-4221.

TEST CHANGE #3

Maternal Serum Screening

Description of Change:
There are several changes to the Maternal Serum Screening tests including test code changes, reporting changes and a new history form (see page 3) taking place on Tuesday February 20th. Here are the main points:

Effective Date: 02/20/2018

New Patient History for Maternal Serum Testing (see page 7):

Changes to the form include:

- Sequential and Integrated #2 tests are no longer listed- the form is not needed for second specimens as long as a previous specimen #1 was performed at ARUP
- "Does the patient currently smoke cigarettes?" will now be mandatory
- The questions concerning a previous pregnancy with a chromosome abnormality is now stated "Has the patient had a previous pregnancy with trisomy (i.e. Down syndrome, Trisomy 18 or 13)"
- Under additional information (Required for Integrated or Sequential screens only):
  1. The appropriate CRL range to perform blood draws for Integrated 1 and Sequential 1 screens are updated:
     Integrated 1: CRL 32.4 to 83.9 mm
     Sequential 1: CRL 43 to 83.9 mm
  2. For all tests: Obtain NT when CRL is 38 to 83.9 mm

Down Syndrome: Smoking will now be factored into the risk calculations- This is the reason the smoking question on the new Patient History for Maternal Screen Testing form is now mandatory.

Changes in risk calculation for Open Neural Tube Defects (ONTD)
Reporting of twin results has been simplified. Expected twin AFP MoMs will now be twice that expected in a singleton (median singleton MoM: 1.00; median twin MoM: 2.00)

Cutoffs will be as follows:
Singleton: 2.50 MoM
Twins: 4.50 MoM
Diabetic (singleton): 1.90 MoM
Diabetic (twins): 2.94 MoM

Changes to the patient report:

- Maternal race will be reported as black, nonblack, or unknown
- Maternal weight will be reported in the units of measurement provided (pounds or kilograms)Units of measurement for PAPP-A will now be reported as ng/mL
- PAPP-P MoMs will no longer be reported on Integrated-1 reports but will be listed as part of the Integrated-2 reports
- Units of measurement for CRL will now be reported in millimeters (mm)
- Interpretation verbiage and formatting changes
- Enhanced report format and design will be updated

Repeat screens will only provide NTD risk
A repeat maternal serum screen will not provide Down syndrome or trisomy 18 risks if the original screen provided risks, and the original sample was drawn within the appropriate gestational age window for the test ordered.

test change continued →

TEST CHANGE #3 continued

Cont. New HNL test codes for Maternal Serum Testing, Effective 2/20/18:		
Old test code	**New test code Effective: 02/20/2018**	**New test name Effective: 02/20/2018**
MAFPS	SAFPM	Maternal Serum Screen, Alpha Fetoprotein
MSS4	MQUAD	Maternal Serum Screen, Alpha Fetoprotein, hCG, Estriol and Inhibin A (Quad)
MSSQ1	SEQM1	Maternal Serum Screening, Sequential, Specimen #1, hCG, PAPP-A, NT
MSSQ2	SEQM2	Maternal Screening, Sequential, Specimen #2, Alpha Fetoprotein, hCG, Estriol and Inhibin A
INTG1	MINT1	Maternal Screening, Integrated, Specimen #1, PAPP-A, NT
INTG2	MINT2	Maternal Serum Screening, Integrated, Specimen #2 Alpha Fetoprotein, hCG, Estriol, and Inhibin A

For more information, please contact Gayle McCarthy at 877-402-4221.

New Patient History for Maternal Serum Testing form (see page 7)→

A nonprofit enterprise of the University of Utah and its Department of Pathology

PATIENT HISTORY FOR MATERNAL SERUM TESTING

The information below is required to perform maternal serum testing. For electronic orders only, please fill out and submit with the electronic packing list.

Client Number_____ Specimen Collection Date_____

Patient Name_____Date of Birth _____

Physician/Genetic Counselor_____ Physician/Genetic Counselor Phone_____

Circle the Maternal Serum Screen test you intend to order.

3000143 Maternal Serum Screen Quad

3000144 Maternal Serum Screen AFP

3000145 Maternal Serum Screen First Trimester

3000146 Maternal Serum Screen Sequential, Specimen 1

3000147 Maternal Serum Screen Integrated, Specimen 1

Required Patient Information

A. Patient's weight: _____lbs. (or) _____kgs.

B. Due date (EDC): _____
Determined by: ❒Last menstrual period, confirmed by ultrasound ❒Ultrasound ❒ Last menstrual period _____

C. Number of fetuses:
❒ Singleton ❒ Twins ❒ Unknown For twins, check box if pregnancy is monochorionic. ❒

D. Patient's race:
❒ Non-Black ❒ Black ❒ Unknown

E. Was the patient diabetic at the time of conception?
❒ No ❒ Yes

F. Does the patient currently smoke cigarettes?
❒ No ❒ Yes

G. Has patient taken valproic acid or carbamazepine during this pregnancy?
❒ No ❒ Yes

H. Has the patient had a previous pregnancy with trisomy (i.e., Down syndrome, Trisomy 18 or 13)
❒ No ❒ Yes If yes, specify abnormality: _____

I. Is there a family history of neural tube defects (i.e., spina bifida, anencephaly, encephalocele)?
❒ No ❒ Yes If yes, relationship of the affected individual to the fetus: _____

J. Is this an in vitro fertilization pregnancy using a donor egg?
❒ No ❒ Yes If yes, age of egg donor: _____yrs.

K. Is this a repeat sample?
❒ No ❒ Yes ❒ Unknown

Additional Information (required for the First Trimester, Integrated, or Sequential screens only)

Ultrasound date:_____ ALL TESTS: Obtain NT when CRL is 38–83.9 mm

Sonographer's name:_____ FMF or NTQR Certification #:_____

Reading MD Name: _____ FMF or NTQR Certification #:_____

CRL (mm): _____ NT (mm)_____ If twins: Twin B CRL (mm) _____Twin B NT (mm)_____

Perform blood draws when CRL is within the appropriate range:

Integrated 1:	CRL 32.4–83.9 mm
Sequential 1:	CRL 43–83.9 mm
First Trimester:	CRL 43–83.9 mm

ARUP label