ARUP® LABORATORIES

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform prenatal cytogenetic testing.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR PRENATAL CYTOGENETICS

Patient's Name ____ **Date of Birth**_____________ ______________

Date of Draw______________________________ **Gestational Age at Draw:** ________**weeks** ________ **days**

Physician/Genetic Counselor___________________________ **Phone**____________________________________

FAX ______________________________ **Pager/Cell:** ___________________________

Sample Type:
- __ Amniotic Fluid
- __ CVS
- __ PUBS
- __ Products of Conception (POC)
- __ Other ___________________________
- __ Maternal blood for MCC studies

Study Type:
- __ Chromosome analysis (karyotype)
- __ Chromosomes with reflex to microarray
- __ Genomic Microarray (aCGH)
- __ Amniotic fluid AFP, with reflex to ACHE
- __ Prenatal FISH panel (13, 18, 21, X & Y)
- __ FISH for a specific locus (specify) ______________________

Fetal Gender by Ultrasound: Male____ Female_____ Ambiguous_____ Unknown______

Indication for testing (check all that apply):
___**Advanced Maternal Age**
___**Abnormal Maternal Serum Screen** T21_____ T18______ High AFP______ Other___________
___ **Familial chromosome abnormality** (provide relationship to fetus, specific abnormality and copy of family member's result)
____
___**Ultrasound Abnormality** (circle the specific finding(s) or list under "other")

Cardiac (VSD ASD TOF HLH Truncus DORV Endocardial Cushion Aortic Stenosis)
Cranial (Ventriculomegaly Holoprosencephaly Agenesis of the Corpus callosum Dandy-Walker)
Fluid Collection (Cystic hygroma Pericardial effusion Pleural effusion Ascites Skin edema Hydrops)
Neural Tube (Spina Bifida Encephalocele Anencephaly Iniencephaly)
Ventral Wall Defect (Omphalocele Gastroschisis Limb-body wall defect)
Positional (Club foot Clenched hands Arthrogryposis Amyoplasia Multiple pterygium)
Skeletal (Thanatophoric Achondroplasia OI Transverse limb reduction Radial ray defect)
Soft Sign (Choroid plexus cyst Echogenic cardiac focus Echogenic Bowel Pyelectasis SUA)
Urinary Tract (Multicystic kidney Renal agenesis Hydronephrosis Posterior urethral valves)
Chest/Abdominal (Diaphragmatic hernia Duodenal atresia Situs Inversus)
Amniotic Fluid (Polyhydramnios Oligohydramnios)

Other____

***DNA testing (specify test)** ____
___ Run test on direct amniotic fluid and keep a backup culture
___ Run test on cultured cells
___ Send cultured cells to (lab name) ____
(Outside lab paperwork must accompany sample)
___Culture/hold cells for possible additional testing

Master Label

***Please complete the Fetal Molecular Genetics Patient History form**.

For questions, contact an ARUP genetic counselor at (800) 242-2787, ext. 2141