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 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
[ ] Products of Conception (POC)
[ ] Other _____
[ ] Maternal blood for MCC studies

Study Type:
[ ] Chromosome analysis (karyotype)
[ ] Genomic Microarray (aCGH)
[ ] Chromosomes with reflex to microarray
[ ] 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_____
[ ] **Abnormal Non-Invasive Prenatal Testing (NIPT) by cffDNA** T21_____ T18_____ T13_____ Other_____
[ ] **Familial chromosome abnormality** (provide relationship to fetus, specific abnormality and copy of family member's result):
_____
[ ] **Fetus with KNOWN chromosome abnormality** (please describe; a copy of the chromosome report is required):
_____
[ ] **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 (Short long bones Short ribs Fractures "Bent" bones 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

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

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

Master Label