ARUP LABORATORIES

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform maternal serum testing.
For electronic orders only, please fill out and submit with the electronic packing list.

PATIENT HISTORY FOR MATERNAL SERUM TESTING

Client Number _____ **Specimen Collection Date** _____

Patient's Name _____ **Date of Birth** _____

Physician/ Genetic Counselor_____ **Phone #** _____

Circle the Maternal Serum Screen test you intend to order.

0080434 Alpha Fetoprotein (Only)
0080108 Alpha Fetoprotein, hCG, & Estriol
0080269 Alpha Fetoprotein, hCG, Estriol, & Inhibin A
0081150 First Trimester
0081062 Integrated, Specimen #1
0081064 Integrated, Specimen #2
0081293 Sequential, Specimen #1
0081294 Sequential, Specimen #2

REQUIRED PATIENT INFORMATION:

A. Current weight _____lbs. (or) _____ kgs.

B. Due date (EDC)_____

Determined by: [ ] Last menstrual period, confirmed by US [ ] Ultrasound [ ] Last menstrual period

C. Number of Fetus:
[ ] Singleton [ ] Twins [ ] Unknown

D. Patient's race?
[ ] Caucasian [ ] Black [ ] Hispanic [ ] Asian [ ] Other

E. At conception, was the patient on medication to control diabetes?
[ ] No [ ] Yes

F. 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? _____

G. Has the patient had a previous pregnancy with a chromosome abnormality? (i.e. Down syndrome, Trisomy 18 or 13)
[ ] No [ ] Yes If yes, specify abnormality _____

H. Is this an *in vitro* fertilization pregnancy using a DONOR egg?
[ ] No [ ] Yes If yes, age of egg donor _____yrs.

I. Has patient taken valproic acid or carbamazepine during this pregnancy?
[ ] No [ ] Yes If yes, specify drug _____

J. Is this a repeat sample?
[ ] No [ ] Yes [ ] Unknown

ADDITIONAL PATIENT INFORMATION (required for the First Trimester, Integrated or Sequential Screens only)

Date of Ultrasound _____

Name of Sonographer _____

Certification # of Sonographer _____

NT (mm) _____

CRL (mm) _____

If twins: Twin B NT (mm)_____

Twin B CRL (mm)_____

Check box if pregnancy is monochorionic. [ ]

All Tests: NT may be obtained when the CRL is 36-85 mm

Blood draws:		
	Integrated -1:	CRL 36 – 85 mm
	Sequential -1:	CRL 42 – 85 mm
	1st Trimester:	CRL 42 – 85 mm

Master Label