ARUP LABORATORIES

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

PATIENT HISTORY FOR FETAL MOLECULAR TESTING

Mother's Name _____ Mother's Date of Birth _____

Physician _____Physician Phone (_____) _____Physician Specialty_____

Genetic Counselor _____ Counselor Phone (_____) _____

Gestational age at draw: _____weeks Test Name_____ Test Number_____

SAMPLE TYPE
[ ] Amniotic fluid * [ ] Direct chorionic villi (Uncultured) * [ ] DNA
[ ] Cultured amniocytes [ ] Cultured chorionic villi [ ] Other _____

* **A backup culture is highly recommended for all amniocentesis/CVS samples.**
Do you need ARUP to start a backup culture? [ ] No [ ] Yes (If yes, order ARUP test #0040182)

Would you like direct testing performed on uncultured chorionic villi or amniotic fluid? [ ] Yes [ ] No
(Since not all tests have been validated on CVS samples, please contact a genetic counselor to discuss testing options. Additionally, if a result is not possible from direct testing for reasons such as inadequate sample or maternal cell contamination, there will be an additional charge for testing cultured cells).

Will you be sending a maternal blood sample for Maternal Cell Contamination studies? [ ] No [ ] Yes
(Highly recommended for proper test interpretation, order ARUP test #0050608)

FETAL ETHNICITY (check all that apply)
[ ] African-American [ ] Ashkenazi Jewish [ ] Asian [ ] Caucasian
[ ] Hispanic [ ] Native American [ ] Other_____

FETAL SEX [ ] Unknown [ ] Male [ ] Female **by** [ ] Ultrasound [ ] FISH/karyotype [ ] NIPT

REASON FOR TESTING (check all that apply)
[ ] Ultrasound findings, explain _____
[ ] Positive family history (please describe below)
[ ] Pregnancy management/delivery planning
[ ] Other _____

IS THERE A FAMILY HISTORY OF THE CONDITION? [ ] Yes [ ] No [ ] Unknown
If yes, what is the specific **RELATIONSHIP** of the family member(s) to the fetus? _____
Is the relative: [ ] a healthy carrier [ ] affected

List the **GENE** and **MUTATION(S)** identified in the family member(s) AND include a copy of the laboratory result_____

_____

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

Master Label