ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

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

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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** ___/___/___ **Sex** ☐ **F** ☐ **M**

Date of Draw ___/___/___ **Gestational Age at Draw** _____ **weeks** _____ **days**

Physician _____ **Physician Phone** (___) _____

Physician Fax _____ **Physician Pager/Cell** (___) _____

Genetic Counselor _____ **Counselor Phone** (___) _____

Sample Type:
- ☐ **Amniotic Fluid**
- ☐ **CVS**
- ☐ **Products of Conception (POC)—fresh or frozen**
- ☐ **Products of Conception (POC)—FFPE**
- ☐ **Maternal blood for MCC studies**
- ☐ **Other**

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)**
- ☐ **Prenatal FISH panel with reflex to either microarray (if normal FISH) or chromosomes (if abnormal FISH)**
- ☐ **FISH for a specific locus (specify):** _____

Fetal gender by ultrasound ☐ Male ☐ Female ☐ Ambiguous ☐ Unknown

For microarray and MCC studies only: Is the patient the biological mother of the fetus? ☐ **Yes** ☐ **No**

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 (please complete the Fetal Molecular Genetics Patient History form)
- ☐ Run test on cultured cells (please complete the Fetal Molecular Genetics Patient History form)
- ☐ Send cultured cells to (lab name) _____

(Outside lab paperwork must accompany sample)
- ☐ Culture/hold cells for possible additional testing (samples retained for 3 weeks)
- ☐ Store long-term back up cultures (samples retained for 6 months)

Master Label

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