ARUP LABORATORIES

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

500 Chipeta Way
Salt Lake City, UT 84108-1221
phone: 801-583-2787 | toll free: 800-242-2787
fax: 801-584-5249 | aruplab.com

THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

PRENATAL CYTOGENETICS PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

Sex Assigned at Birth: ☐Female ☐Male ☐Intersex **Gender Identity (optional):** ☐Female ☐Male ☐_____

Ordering Provider: _____ **Provider's Phone:** _____

Practice Specialty: _____ **Provider's Fax:** _____

Genetic Counselor: _____ **Counselor's Phone:** _____

Date of Draw: _____ **Gestational Age at Draw:** _____ **weeks** _____ **days**

Chorionic Villus (CVS)

☐ ***0040203*** *CVS, FISH*

☐ ***2002291*** *Chromosome Analysis, CVS*

☐ ***2002366*** *Cytogenomic SNP Microarray—Fetal*

☐ ***2011131*** *Chromosome FISH, CVS with Reflex to Chromosome Analysis or Genomic Microarray*

Amniotic Fluid (AF)

☐ ***2002297*** *Chromosome FISH, Prenatal*

☐ ***2002293*** *Chromosome Analysis, AF*

☐ ***2002366*** *Cytogenomic SNP Microarray—Fetal*

☐ ***2008367*** *Chromosome Analysis, Amniotic Fluid, with Reflex to Genomic Microarray*

☐ ***2011130*** *Chromosome FISH, AF with Reflex to Chromosome Analysis or Genomic Microarray*

☐ ***3000142*** *Alpha Fetoprotein (AF) with Reflex to Acetylcholinesterase and Fetal Hemoglobin*

Products of Conception; Fresh/FFPE (POC)

☐ ***2002288*** *Chromosome Analysis, POC*

☐ ***2005633*** *Genomic SNP Microarray, POC*

☐ ***2005762*** *Chromosome Analysis, POC, with Reflex to Genomic Microarray*

☐ ***3004273*** *Cytogenomic Molecular Inversion Probe Array, FFPE Tissue—POC*

Maternal Blood

☐ ***0050608*** *Maternal Cell Contamination (MCC), Maternal Specimen*

Fetal sex by ☐ ultrasound or ☐ cfDNA screening: ☐ Male ☐ Female ☐ Ambiguous ☐ Unknown

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

Is there consanguinity? ☐ No ☐ Yes

Indication for testing (check all that apply)

☐ Advanced maternal age

☐ High risk maternal serum screen: ☐ T21 ☐ T18 ☐ High AFP

☐ Other: _____

☐ High-risk cfDNA (NIPT): ☐ T21 ☐ T18 ☐ T13 ☐ TS ☐ SCA

☐ Atypical cfDNA: CHR _____ ☐ Other: _____

☐ Familial chromosome abnormality (provide relationship to fetus, specific abnormality, and a copy of the family member's result):

_____

☐ Fetus with KNOWN chromosome abnormality (describe and provide a copy of the previous report):

_____

Ultrasound abnormality (check findings below or list under "other")

Abdominal/Chest
☐ Diaphragmatic hernia
☐ Duodenal atresia

Amniotic Fluid
☐ Oligohydramnios
☐ Polyhydramnios

Cardiac
☐ ASD ☐ VSD
☐ HLH ☐ TOF
☐ Aortic Stenosis
☐ Other: _____

Neural Tube
☐ Anencephaly
☐ Encephalocele
☐ Spina bifida

Cranial Facial
☐ Agenesis of the corpus callosum
☐ Absent CSP
☐ Cleft lip
☐ Dandy-Walker
☐ Holoprosencephaly
☐ Hydrocephaly
☐ Microcephaly
☐ Micrognathia
☐ Ventriculomegaly

Fetal Well-Being
☐ Fetal demise
☐ IUGR
☐ SGA/size < dates

Fluid Collection
☐ Ascites
☐ Cystic hygroma
☐ Hydrops
☐ Increased NT
☐ Skin edema
☐ Pericardial effusion
☐ Pleural effusion

Limb/Joint
☐ Arthrogryposis
☐ Clenched hands
☐ Clubfoot
☐ Polydactyly
☐ Rocker bottom foot
☐ Syndactyly

Markers/Soft Signs
☐ Absent nasal bone
☐ Pyelectasis
☐ Choroid plexus cyst
☐ SUA
☐ Echogenic bowel
☐ Echogenic cardiac focus
☐ Thickened nuchal fold

Skeletal
☐ "Bent" bones
☐ Radial ray defect
☐ Short long bones
☐ Short ribs
☐ Vertebral anomalies

Urinary Tract
☐ Bladder exstrophy
☐ Bladder outlet obstruction
☐ Hydronephrosis
☐ Multicystic kidney
☐ Posterior urethral valves
☐ Renal agenesis

Ventral Wall Defect
☐ Gastroschisis
☐ Limb-body wall defect
☐ Omphalocele

☐ Other: _____

Additional Testing on Sample

ARUP keeps a backup culture for 3 weeks from the date of report. If additional testing/cultures are desired, please check option(s) below and order **ARUP test #3020627 (CGCELLCULT)**.

☐ Culture cells for additional testing. Test desired: _____

☐ Store long-term backup cultures (two T-25 flasks frozen and retained for 6 months)

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

Master Label