ARUP LABORATORIES

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

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

FETAL MOLECULAR TESTING 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 Collection: _____ **Gestational Age at Collection**: _____weeks_____days

Fetal Ethnicity/Ancestry (check all that apply)

☐ African American/Black ☐ Asian ☐ Hispanic or Latino ☐ White ☐ Other: _____

List country of origin (if known): _____

Fetal Sex: ..... ☐ Unknown ☐ Male ☐ Female
Indicated by: ..... ☐ Ultrasound ☐ FISH/Karyotype ☐ NIPT

Is the patient the biological parent of the fetus? .....☐ Yes ☐ No

Reason for referral:
☐ Positive family history ☐ Ultrasound findings (explain): _____
☐ Pregnancy management/delivery planning ☐ Other: _____

Is there any relevant family history of the condition?..... ☐ No ☐ Yes ☐ Unknown
Attach a pedigree or specify the relationship of the family member(s) to the patient: _____

Has DNA testing been performed for the family member(s)? ..... ☐ No ☐ Yes ☐ Unknown

If yes, attach a copy of the relative's DNA laboratory result: (REQUIRED for familial variant testing)

The relative is:..... ☐ A healthy carrier ☐ Affected

List the gene and variant(s) identified in the family member: _____

Sample type to be tested
☐ Amniotic fluid * ☐ Cultured chorionic villi ☐ DNA
☐ Cultured amniocytes ☐ Direct chorionic villi (uncultured) * ☐ 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 # 3020627)

Note: Please contact an ARUP genetic counselor to confirm the validated fetal sample type(s) for the test/gene of interest. If cell culture is requested at ARUP, additional fees will apply.

Will you be sending a maternal blood sample for Maternal Cell Contamination studies? ..... ☐ No ☐ Yes
(Highly recommended for test interpretation; order ARUP test #0050608)

☐ Other: _____

Master Label

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