

## 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: Gender Identity (optional): □ Female □Male □		
Sex Assigned at Birth: $\Box$ Female $\Box$ Male $\Box$ Intersex			
Ordering Provider:			
Practice Specialty:			
Genetic Counselor: Date of Collection:		wooko	dava
Fetal Ethnicity/Ancestry (check all that apply)	Gestational Age at Collection	weeks_	uays
	White 🛛 Other.		
List country of origin (if known):			
Fetal Sex:		□ Male	□ Female
Indicated by:		□ FISH/Karyotype	
Is the patient the biological parent of the fetus?			
Reason for referral:			
	ound findings (explain):		
□ Pregnancy management/delivery planning □ Other			
Is there any relevant <u>family history</u> of the condition? Attach a <u>pedigree</u> or specify the <u>relationship</u> of the family mer		□ Yes	🗆 Unknown
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: (RE	QUIRED for familial variant tes	sting)	
The relative is:	🗆 A he	althy carrier	□ Affected
List the gene and variant(s) identified in the family member:			
Sample type to be tested			
□ Amniotic fluid * □ Cultured chorionic vi			
□ Cultured amniocytes □ Direct chorionic villi (			
*A backup culture is highly recommended for all amniocentesis/CV	-		
Do you need ARUP to start a backup culture?	•	-	
Note: Please contact an ARUP genetic counselor to confirm the cell culture is requested at ARUP, additional fees will appl		) for the test/gene of	Interest. If
Will you be sending a maternal blood sample for Maternal Cell ( (Highly recommended for test interpretation; order ARUP test #			No 🗆 Yes
□ Other			
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For guestions, contact an ARUP genetic counselor at 800-2	242-2787 ext. 2141.		