

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)	Amniotic Fluid (AF)	Products of Conception; Fresh/FFPE (POC)
<input type="checkbox"/> 0040203 CVS, FISH	<input type="checkbox"/> 2002297 Chromosome FISH, Prenatal	<input type="checkbox"/> 2002288 Chromosome Analysis, POC
<input type="checkbox"/> 2002291 Chromosome Analysis, CVS	<input type="checkbox"/> 2002293 Chromosome Analysis, AF	<input type="checkbox"/> 2005633 Genomic SNP Microarray, POC
<input type="checkbox"/> 2002366 Cytogenomic SNP Microarray—Fetal	<input type="checkbox"/> 2002366 Cytogenomic SNP Microarray—Fetal	<input type="checkbox"/> 2005762 Chromosome Analysis, POC, with Reflex to Genomic Microarray
<input type="checkbox"/> 2011131 Chromosome FISH, CVS with Reflex to Chromosome Analysis or Genomic Microarray	<input type="checkbox"/> 2008367 Chromosome Analysis, Amniotic Fluid, with Reflex to Genomic Microarray	<input type="checkbox"/> 3004273 Cytogenomic Molecular Inversion Probe Array, FFPE Tissue—POC
	<input type="checkbox"/> 2011130 Chromosome FISH, AF with Reflex to Chromosome Analysis or Genomic Microarray	Maternal Blood
	<input type="checkbox"/> 3000142 Alpha Fetoprotein (AF) with Reflex to Acetylcholinesterase and Fetal Hemoglobin	<input type="checkbox"/> 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)

<input type="checkbox"/> Advanced maternal age	<input type="checkbox"/> Familial chromosome abnormality (provide relationship to fetus, specific abnormality, and a copy of the family member's result): _____
<input type="checkbox"/> Abnormal maternal serum screen: <input type="checkbox"/> T21 <input type="checkbox"/> T18 <input type="checkbox"/> High AFP <input type="checkbox"/> Other: _____	<input type="checkbox"/> Fetus with KNOWN chromosome abnormality (describe and provide a copy of the chromosome report): _____
<input type="checkbox"/> Abnormal cfDNA (NIPS): <input type="checkbox"/> T21 <input type="checkbox"/> T18 <input type="checkbox"/> T13 <input type="checkbox"/> TS <input type="checkbox"/> SCA <input type="checkbox"/> Atypical: CHR <input type="checkbox"/> Other: _____	

Ultrasound abnormality (check finding[s] or list under "other")

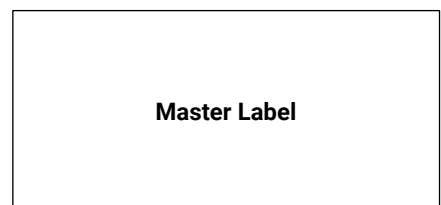
Abdominal/Chest	Cranial Facial	Fluid Collection	Markers/Soft Signs	Urinary Tract
<input type="checkbox"/> Diaphragmatic hernia	<input type="checkbox"/> Agenesis of the corpus callosum	<input type="checkbox"/> Ascites	<input type="checkbox"/> Absent nasal bone	<input type="checkbox"/> Bladder exstrophy
<input type="checkbox"/> Duodenal atresia	<input type="checkbox"/> Absent CSP	<input type="checkbox"/> Cystic hygroma	<input type="checkbox"/> Pyelectasis	<input type="checkbox"/> Bladder outlet obstruction
Amniotic Fluid	<input type="checkbox"/> Cleft lip	<input type="checkbox"/> Hydrops	<input type="checkbox"/> Choroid plexus cyst	<input type="checkbox"/> Hydronephrosis
<input type="checkbox"/> Oligohydramnios	<input type="checkbox"/> Dandy-Walker	<input type="checkbox"/> Increased NT	<input type="checkbox"/> SUA	<input type="checkbox"/> Multicystic kidney
<input type="checkbox"/> Polyhydramnios	<input type="checkbox"/> Hydrocephaly	<input type="checkbox"/> Skin edema	<input type="checkbox"/> Echogenic bowel	<input type="checkbox"/> Posterior urethral valves
Cardiac	<input type="checkbox"/> Holoprosencephaly	<input type="checkbox"/> Pericardial effusion	<input type="checkbox"/> Echogenic cardiac focus	<input type="checkbox"/> Renal agenesis
<input type="checkbox"/> ASD <input type="checkbox"/> VSD	<input type="checkbox"/> Microcephaly	<input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Thickened nuchal fold	<input type="checkbox"/> Renal Wall Defect
<input type="checkbox"/> HLH <input type="checkbox"/> TOF	<input type="checkbox"/> Micrognathia	Limb/Joint	Skeletal	<input type="checkbox"/> Gastroschisis
<input type="checkbox"/> Aortic Stenosis	<input type="checkbox"/> Ventriculomegaly	<input type="checkbox"/> Arthrogryposis	<input type="checkbox"/> "Bent" bones	<input type="checkbox"/> Limb-body wall defect
<input type="checkbox"/> Other: _____	Fetal Well-Being	<input type="checkbox"/> Clenched hands	<input type="checkbox"/> Radial ray defect	<input type="checkbox"/> Omphalocele
Neural Tube	<input type="checkbox"/> Fetal demise	<input type="checkbox"/> Clubfoot	<input type="checkbox"/> Short long bones	
<input type="checkbox"/> Anencephaly	<input type="checkbox"/> IUGR	<input type="checkbox"/> Polydactyly	<input type="checkbox"/> Short ribs	
<input type="checkbox"/> Encephalocele	<input type="checkbox"/> SGA/size < dates	<input type="checkbox"/> Rocker bottom foot	<input type="checkbox"/> Vertebral anomalies	
<input type="checkbox"/> Spina bifida		<input type="checkbox"/> Syndactyly		

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 #0040182 (CG GRW&SND).

- 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.