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.

PATIENT HISTORY FOR FETAL MOLECULAR TESTING

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ Female ☐ Male

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

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

Genetic Counselor: _____ **Counselor Phone:** _____

Fetal Ethnicity/Ancestry (check all that apply)

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

List country of origin (if known): _____

Fetal Sex ☐Unknown ☐Male ☐Female

Indicated by ☐ Ultrasound ☐FISH/Karyotype ☐NIPT

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 mutation testing)

The relative is: ☐ a healthy carrier ☐ affected

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

Sample Type

☐ 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 #0040182)

Would you like direct testing performed on uncultured chorionic villi or amniotic fluid? ☐ No ☐ Yes

Note: Since not all tests have been validated on CVS samples, please contact a genetic counselor to discuss testing options. Additionally, if a result is not possible from direct testing for reasons such as inadequate sample or maternal cell contamination, there will be an additional charge for testing cultured cells.

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

Check the test you intend to order.

☐ **0040182 Cytogenetics Grow and Send**

☐ **0050608 Maternal Cell Contamination, Maternal Specimen**

☐ **2001980 Familial Mutation, Targeted Sequencing Fetal**: Tests for a mutation previously identified in a family member; a copy of relative's lab result is REQUIRED.

Master Label

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