

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")

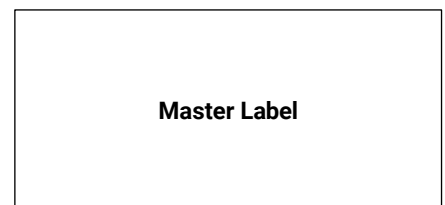
Abdominal/Chest	Cranial Facial	Fluid Collection	Markers/Soft Signs	Urinary Tract
<input type="checkbox"/> Diaphragmatic hernia	<input type="checkbox"/> Agenesis of the corpus callosum	<input type="checkbox"/> Ascites	<input type="checkbox"/> Absent nasal bone	<input type="checkbox"/> Bladder exstrophy
<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"/> Holoprosencephaly	<input type="checkbox"/> Skin edema	<input type="checkbox"/> Echogenic bowel	<input type="checkbox"/> Posterior urethral valves
Cardiac	<input type="checkbox"/> Hydrocephaly	<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"/> Ventral Wall Defect
<input type="checkbox"/> HLH <input type="checkbox"/> TOF	<input type="checkbox"/> Micrognathia	Limb/Joint	<input type="checkbox"/> 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.