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.

NONINVASIVE PRENATAL ANEUPLOIDY SCREEN BY CELL-FREE DNA SEQUENCING
PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

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

Number of Fetuses (REQUIRED*): ☐ Singleton ☐ Twins** ☐ Triplets **

*If an option is NOT checked, ARUP will not perform testing. Testing will be canceled upon receipt at ARUP.

**ARUP only performs testing on singleton pregnancies. Multiple gestations will be sent out to Integrated Genetics to perform the MaterniT21 PLUS Core Test (test code 451927)

Is the gestational age at draw ≥ 10 weeks? (REQUIRED): ☐ No* ☐ Yes

*Testing will NOT be performed for patients with a gestational age <10 weeks. Testing will be canceled upon receipt at ARUP.

Gestational age: _____ weeks OR Estimated date of conception (EDC): _____ (Optional)

Does the patient want the sex of the fetus reported? ☐ No ☐ Yes
(Sex will be reported if not specified)

Patient's weight at draw: _____lbs OR _____kgs

Does the patient have a family history of chromosomal abnormalities or personal history in previous pregnancies? ☐ No ☐ Yes

(If yes, please specify): _____

Has the patient had a high-risk screening result in this pregnancy? ☐ No ☐ Yes

Specify high risk result: ☐ T21 ☐ T18 ☐ T13 ☐ Neural tube defect (NTD)

☐ Other: _____

Specify test method: ☐ Maternal serum screening (MSS) ☐ cfDNA screening

Has the patient had an abnormal ultrasound in this pregnancy? ☐ No ☐ Yes

(If yes, please specify): _____

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

Master Label