ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

500 Chipeta Way
Salt Lake City, UT 84108-1221
phone: 801-583-2787 | toll free: 800-242-2787
fax: 801-584-5249 | aruplab.com

THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

PATIENT HISTORY FORM FOR PRENATAL CYTOGENETICS

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ 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 Acetylcholinesterase and Fetal Hemoglobin
- ☐ **2008367** Chromosome Analysis, AF, with Reflex to Genomic Microarray

Products of Conception; Fresh/FFPE (POC)
- ☐ **2002288** Chromosome Analysis, POC
- ☐ **2005633** Genomic SNP Microarray, POC
- ☐ **2005762** Chromosome Analysis, POC, with Reflex to Genomic Microarray
- ☐ **2010795** Cytogenomic Molecular Inversion Probe Array, FFPE Tissue—POC

Maternal Blood
- ☐ **0050608** Maternal Cell Contamination, Maternal Specimen
- ☐ **2002369** Microarray Genomic, Maternal Confirm

Fetal sex by ultrasound: ☐ Male ☐ Female ☐ Ambiguous ☐ Unknown

For microarray and MCC studies only:
Is the patient the biological mother of the fetus? ☐ No ☐ Yes
Is there consanguinity? ☐ No ☐ Yes

Indication for Testing (check all that apply)
- ☐ Advanced maternal age
- ☐ Abnormal maternal serum screen: ☐ T21 ☐ T18 ☐ High AFP ☐ Other: _____
- ☐ Abnormal cfDNA (NIPT): ☐ T21 ☐ T18 ☐ T13 ☐ TS ☐ SCA ☐ Atypical: 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 chromosome report): _____

☐ Ultrasound Abnormality (check finding(s) or list under "other")

Abdominal/Chest
- ☐ Diaphragmatic hernia
- ☐ Duodenal atresia

Amniotic Fluid
- ☐ Oligohydramnios
- ☐ Polyhydramnios

Cardiac
- ☐ ASD ☐VSD
- ☐ HLH ☐TOF
- ☐ Aortic Stenosis
- ☐ Other: _____

Neural Tube
- ☐ Anencephaly
- ☐ Encephalocele
- ☐ Spina bifida

Cranial Facial
- ☐ Agenesis of the corpus callosum
- ☐ Absent CSP
- ☐ Cleft lip
- ☐ Dandy-Walker
- ☐ Holopresencephaly
- ☐ Hydrocephaly
- ☐ Microcephaly
- ☐ Micrognathia
- ☐ Ventriculomegaly

Fetal Well-Being
- ☐ Fetal demise
- ☐ IUGR
- ☐ SGA/size < dates

Fluid Collection
- ☐ Ascites
- ☐ Cystic hygroma
- ☐ Hydrops
- ☐ Increased NT
- ☐ Skin edema
- ☐ Pericardial effusion
- ☐ Pleural effusion

Limb/Joint
- ☐ Arthrogryposis
- ☐ Clenched hands
- ☐ Clubfoot
- ☐ Polydactyly
- ☐ Rocker bottom foot
- ☐ Syndactyly

Markers/Soft Signs
- ☐ Absent nasal bone
- ☐ Pyelectasis
- ☐ Choroid plexus cyst
- ☐ SUA
- ☐ Echogenic bowel
- ☐ Echogenic Cardiac focus
- ☐ Thickened nuchal fold

Skeletal
- ☐ "Bent" Bones
- ☐ Radial ray defect
- ☐ Short long bones
- ☐ Short ribs
- ☐ Vertebral anomalies

Urinary Tract
- ☐ Bladder exstrophy
- ☐ Bladder outlet obstruction
- ☐ Hydronephrosis
- ☐ Multicystic kidney
- ☐ Posterior Urethral Valves
- ☐ Renal agenesis

Ventral Wall Defect
- ☐ Gastroschisis
- ☐ Limb-body wall defect
- ☐ Omphalocele

☐ Other: _____

Additional Testing on **Sample**
- ☐ Culture cells for additional testing. Test desired: _____
- ☐ Culture/hold cells for possible additional testing (samples retained for 3 weeks)
- ☐ Store long-term back-up cultures (two T-25 flasks frozen and retained for 6 months)

Master Label

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