ARUP LABORATORIES

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform maternal serum testing.
For electronic orders only, please fill out and submit with the electronic packing list.

PATIENT HISTORY FOR MATERNAL SERUM TESTING

Client Number_____ Specimen Collection Date_____

Patient Name_____ Date of Birth _____

Physician _____ Physician Phone (_____) _____

Genetic Counselor _____ Counselor Phone (_____) _____

Circle the Maternal Serum Screen test you intend to order.

0081062 Integrated, Specimen #1	0081293 Sequential, Specimen #1	0080434 Alpha Fetoprotein (Only)
0081064 Integrated, Specimen #2	0081294 Sequential, Specimen #2	0080108 Alpha Fetoprotein, hCG, & Estriol (Triple)
	0081150 First Trimester	0080269 Alpha Fetoprotein, hCG, Estriol, & Inhibin A (Quad)

REQUIRED PATIENT INFORMATION:

A. Current weight_____lbs. (or)_____kgs.

B. Due date (EDC)_____
Determined by: [ ] Last menstrual period, confirmed by US [ ] Ultrasound [ ] Last menstrual period

C. Number of Fetus
[ ] Singleton [ ] Twins [ ] Unknown Check box if pregnancy is monochorionic. [ ]

D. Patient's race?
[ ] Caucasian [ ] Black [ ] Hispanic [ ] Asian [ ] Other

E. Was the patient diabetic at the time of conception?
[ ] No [ ] Yes

F. Is there a family history of neural tube defects (i.e., spina bifida, anencephaly, encephalocele)?
[ ] No [ ] Yes If yes, relationship of the affected individual to the fetus? _____

G. Has the patient had a previous pregnancy with a chromosome abnormality (i.e., Down syndrome, Trisomy 18 or 13)?
[ ] No [ ] Yes If yes, specify abnormality _____

H. Is this an *in vitro* fertilization pregnancy using a DONOR egg?
[ ] No [ ] Yes If yes, age of egg donor_____yrs.

I. Has patient taken valproic acid or carbamazepine during this pregnancy?
[ ] No [ ] Yes If yes, specify drug _____

J. Is this a repeat sample?
[ ] No [ ] Yes [ ] Unknown

K. Does the patient currently smoke cigarettes?
[ ] No [ ] Yes [ ] Unknown

ADDITIONAL PATIENT INFORMATION (required for the First Trimester, Integrated or Sequential Screens only)

Date of Ultrasound_____ All Tests: NT may be obtained when the CRL is 39-85 mm

Sonographer Name_____ Certification # _____

Reading MD Name_____ Certification # _____

NT (mm)_____ CRL (mm)_____ If twins: Twin B NT (mm)_____ Twin B CRL (mm) _____

Blood draws: Integrated -1: CRL 34 – 85 mm
Sequential -1: CRL 44 – 85 mm
1st Trimester: CRL 44 – 85 mm

Master Label