ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY
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 fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR PRENATAL CYTOGENETICS

Patient Name _____ Date of Birth _____ Sex ☐ F ☐ M

Physician _____ Physician Phone _____

Practice Specialty _____ Physician Fax _____

Genetic Counselor _____ Counselor Phone _____

Date of Draw _____ Gestational Age at Draw _____ weeks _____ days

Sample Type
- ☐ Amniotic fluid
- ☐ CVS
- ☐ Products of conception (POC), fresh or frozen
- ☐ Products of conception (POC), FFPE
- ☐ Maternal blood for MCC studies
- ☐ Other (specify): _____

Study Type (stand-alone tests)
- ☐ Chromosome analysis (karyotype)
- ☐ Genomic microarray (aCGH)
- ☐ Prenatal FISH panel (13, 18, 21, X & Y)
- ☐ FISH for a specific locus (specify): _____

Study Type (reflex tests)
- ☐ Chromosomes with reflex to microarray
- ☐ Prenatal FISH panel with reflex to either microarray (if normal FISH) or chromosomes (if abnormal FISH)
- ☐ Amniotic fluid AFP, with reflex to ACHE

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

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

Indication for Testing (check all that apply)
- ☐ Advanced maternal age
- ☐ Abnormal maternal serum screen ☐ T21 ☐ T18 ☐ High AFP ☐ Other: _____
- ☐ Abnormal non-invasive prenatal testing (NIPT) by cfDNA ☐ T21 ☐ T18 ☐ T13 ☐ Other: _____
- ☐ Familial chromosome abnormality (provide relationship to fetus, specific abnormality and copy of family member's result): _____
- ☐ Fetus with KNOWN chromosome abnormality (describe and provide a copy of the chromosome report) _____
- ☐ Ultrasound Abnormality (check the specific finding(s) or list under "other")

Abdominal/Chest
- ☐ Diaphragmatic hernia
- ☐ Duodenal atresia
- ☐ Situs Inversus

Amniotic Fluid
- ☐ Oligohydramnios
- ☐ Polyhydramnios

Cardiac
- ☐ ASD ☐ DORV
- ☐ HLH ☐ TOF
- ☐ VSD ☐ Truncus
- ☐ Aortic stenosis
- ☐ Cardiomegaly
- ☐ Endocardial cushion
- ☐ Pulmonary atresia

Cranial/Facial
- ☐ Agenesis of the corpus callosum
- ☐ Absent CSP
- ☐ Cleft lip ± palate
- ☐ Dandy-Walker
- ☐ Holoprosencephaly
- ☐ Hydrocephaly
- ☐ Microcephaly
- ☐ Micrognathia
- ☐ Ventriculomegaly

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

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

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

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

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

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

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 (2 T-25 flasks frozen and retained for 6 months)

Master Label

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