

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

## MATERNAL SERUM TESTING PATIENT HISTORY FORM

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Client Number: \_\_\_\_\_ Specimen Collection Date: \_\_\_\_\_  
Physician: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_  
Genetic Counselor: \_\_\_\_\_ Counselor's Phone: \_\_\_\_\_

Patient's weight \_\_\_\_\_ lbs OR \_\_\_\_\_ kgs

Due date (EDC) \_\_\_\_\_ Determined by: ☐ last menstrual period, confirmed by ultrasound  
☐ last menstrual period date: \_\_\_\_\_  
☐ ultrasound

**Number of fetuses?**

☐ Singleton ☐ Twins ☐ Unknown For twins, is pregnancy monochorionic? ☐ No ☐ Yes ☐ Unknown

**Patient's race?**

☐ Non-Black ☐ Black ☐ Unknown

**Did the patient have insulin-dependent diabetes at time of conception?**

☐ No ☐ Yes

**Does the patient currently smoke cigarettes?**

☐ No ☐ Yes

**Has the patient taken valproic acid or carbamazepine during this pregnancy?**

☐ No ☐ Yes; specify medication: \_\_\_\_\_

**Has the patient had a previous pregnancy with trisomy? (i.e., Down syndrome, trisomy 18 or 13)**

☐ No ☐ Yes; specify abnormality: \_\_\_\_\_

**Is there a family history of neural tube defects? (i.e., spina bifida, anencephaly, encephalocele)**

☐ No ☐ Yes; specify the relationship of the affected individual to the fetus: \_\_\_\_\_

**Is this an in vitro fertilization pregnancy?**

☐ No ☐ Yes; specify the age of the egg donor, if used: \_\_\_\_\_ years

**Has the patient had a previous maternal serum screen in this pregnancy?**

☐ No ☐ Yes ☐ Unknown

**Additional Information (required for the First Trimester, Integrated, or Sequential screens only)**

Ultrasound date: \_\_\_\_\_ ALL TESTS: Obtain NT when CRL is 38–83.9 mm  
Sonographer's Name: \_\_\_\_\_ FMF or NTQR Certification # \_\_\_\_\_  
Reading MD Name: \_\_\_\_\_ FMF or NTQR Certification # \_\_\_\_\_  
CRL (mm): \_\_\_\_\_ NT (mm): \_\_\_\_\_ Twin B CRL (mm): \_\_\_\_\_ Twin B NT (mm): \_\_\_\_\_

**Select the test you intend to order.**

- ☐ 3000143 Maternal Serum Screen, Quad  
☐ 3000144 Maternal Serum Screen, AFP  
☐ 3000145 Maternal Serum Screen, First Trimester  
☐ 3000146 Maternal Serum Screen, Sequential, Specimen 1  
☐ 3000147 Maternal Serum Screen, Integrated, Specimen 1

**Perform blood draws when CRL is within the appropriate range:**

Integrated 1: CRL 32.4–83.9 mm  
Sequential 1: CRL 43–83.9 mm  
First Trimester: CRL 43–83.9 mm

ARUP Master Label

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