NATIONWIDE CHILDREN'S

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GENETIC PRENATAL TEST REQUISITION – INTERNAL FORM

PATIENT FULL NAME AND SECOND IDENTIFIER	REQUESTING PHYSICIAN INFORMATION
LAST NAME:	PHYSICIAN NAME (PLEASE PRINT):
FIRST NAME:	
DOB/MRN:	EMAIL:
AFFIX PATIENT LABEL HERE IF AVAILABLE	PHONE:
	FAX:
	SIGNATURE (REQUIRED):

CLINICAL INFORMATION

CLINICAL HISTORY PERTINENT TO THIS ANALYSIS (REQUIRED):

SPECIMEN INFORMATION

PRIORITY: [ ] ROUTINE [ ] STAT COLLECTION DATE: _____ COLLECTION TIME: _____ PATIENT UNIT: _____

COLLECTOR'S FULL NAME:_____ EMPLOYEE ID #: _____ UNIT'S PHONE: _____

PRENATAL TEST REQUISITION FORM

Gestation:____weeks____days ; Grav:____ Para:___ SAb:___ TAb:___
Fetal Sex: [ ] Male [ ] Female [ ] Unknown
Egg Donor Used for This Pregnancy? [ ] No [ ] Yes
Specimen: [ ] Amniotic Fluid (AF): Volume _____mL; Color_____
[ ] Fetal Fluid: Source _____ , Volume ____mL
[ ] PUBS Fetal Blood: Volume ____mL (≥1 mL NaHep)

CYTOGENETIC TESTING, PRENATAL SPECIMEN
[ ] Chromosome Analysis, Full Study (15 Colonies) (≥20mL AF requested)
[ ] 5-cell Abbreviated Chromosome Analysis (≥5mL AF requested)
[ ] Aneuploidy FISH Screen for 13,18,21,X,Y (addt'l 5mL AF requested)

MICROARRAY ANALYSIS, PRENATAL SPECIMEN
***Maternal blood is REQUIRED for all Prenatal Microarray Tests**
***If <20mL AF submitted, Microarray will be done on cultured AF cells**
A. [ ] Prenatal Microarray **with Parental Testing**-[ ] Run if full karyotype normal
[ ] Maternal blood enclosed (4mL EDTA) - REQUIRED
[ ] Paternal blood enclosed (4mL EDTA) - Complete a separate requisition form for the Father of Pregnancy -
Father's Name & DOB_____
B. [ ] Prenatal Microarray (**No Parental Testing**)-[ ] Run if full karyotype normal
[ ] Maternal blood enclosed (4mL EDTA) - REQUIRED

OTHER AMNIOTIC FLUID (AF) / PRENATAL SPECIMEN TESTING:
[ ] AF-AFP, Reflex to AChE & Fetal Hb (test code XAFRA)
[ ] Infectious Disease Qualitative PCR, Choose Below:
[ ] CMV (test code CMVTT) [ ] Parvo B19 (test code B19PCR)
[ ] Toxoplasma (test code XTOXG) [ ] HSV (test code HSVTT)
[ ] SLO/7-DHC Biochem Study (test code 7DHCA)
[ ] Other FISH Study: ___22q11, ___STS, Other_____
[ ] DNA Isolation & Cryopreservation of Cultured Amniocytes
[ ] Cryopreservation of Cultured Amniocytes (No DNA Isolation)
[ ] Culture Cells for Additional Test (addt'l 10 mL AF requested), Specify
Test/Lab _____
_____

***For fetal DNA testing, send 4mL EDTA maternal blood with AF**

MATERNAL / PATERNAL TESTING: ___mL NaHep; ___mL EDTA
[ ] BLOOD Chromosome Analysis (4mL NaHep)
[ ] BLOOD Microarray Analysis (4mL EDTA)
[ ] Maternal Cell Contamination (MCC) Studies (4mL EDTA)
Proband Name:_____ DOB:_____
[ ] Other: _____
[ ] Fragile X (4mL EDTA): ____Carrier Test OR ____Diagnostic Test
[ ] Spinal Muscular Atrophy (SMA) Dosage Analysis (4 mL EDTA)
For ____ Carrier Screening OR ____ Diagnostic Testing
[ ] Cystic Fibrosis Common Mutation Panel (4mL EDTA)
For ____ Carrier Screening OR ____ Diagnostic Testing
Family History of CF? ___No ___Yes, Relative_____
_____(eg. sister) is ___Carrier ___Affected

INDICATIONS FOR STUDY ** REQUIRED **
Please provide indication for testing and relevant clinical and family history to allow accurate interpretation of test results.
[ ] Advanced Maternal Age
[ ] Abnormal ___First Trimester Screen ___Quad Screen
___Cell-free Fetal DNA Screen (NIPS/NIPT)
Down synd risk:_____ Other: _____
[ ] 2 or More Spontaneous Abortions
[ ] Family History (describe below)
[ ] Ultrasound Abnormality (describe below)
[ ] Other (describe below)
Clinical Findings:_____
_____
_____

Genetic Counselor Name: _____
Cytogenetics Lab: TEL 614-722-5321 FAX 614-722-5471
After Hours: TEL 614-722-5351 for specimen pickup
TEL (614) 722-5477 for questions