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/ Genetic Counselor ______________________________ **Phone #** ________________

Circle the Maternal Serum Screen test you intend to order.

0081062 Integrated, Specimen #1
0081064 Integrated, Specimen #2

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. Center to which abnormal results are to be called ____

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

Date of Ultrasound ______________________ <u>All Tests:</u> NT may be obtained when the CRL is 36-85 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 36 – 85 mm
Sequential -1:	CRL 42 – 85 mm
1st Trimester:	CRL 42 – 85 mm

Master Label