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 Last Name _____ **First Name** _____**MI** _____

Date of Birth _____

Physician/ Genetic Counselor_____ Phone # _____

Comments or Special Instructions_____

_____

REQUIRED PATIENT INFORMATION:

A. Current weight _____lbs.

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

C. Number of Fetus:
[ ] Singleton [ ] Twins [ ] Triplets [ ] Unknown

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

E. Is patient insulin dependant diabetic?
[ ] No [ ] Yes

F. Is there a family history of neural tube defect?
[ ] No [ ] Yes If yes, relationship to fetus? _____

G. Has the patient had a previous pregnancy with a chromosome abnormality? (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

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

Date of Ultrasound _____
Name of Sonographer _____
Certification # of Sonographer _____
Reading M.D. _____
NT (mm) _____
CRL (cm) _____
If twins: Twin B NT (mm)_____
Twin B CRL (cm)_____
Check box if pregnancy is monochorionic. [ ]

Master Label