ARUP LABORATORIES

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 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 Phone:** _____

Genetic Counselor: _____ **Counselor 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

Was the patient diabetic at the 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 38-83.9mm**

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 ¦ 83.9mm
Sequential 1: CRL 43 ¦ 83.9mm
First Trimester: CRL 43 ¦ 83.9mm

ARUP Master Label

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