

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



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