

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

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 Certification # _____
Reading MD's Name: _____ FMF 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

ARUP Master Label

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