

PRENATAL TESTING REQUISITION

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**SPECIMEN INFORMATION**

\*Collection date \_\_\_\_\_ Institution \_\_\_\_\_ Time of Collection \_\_\_\_\_  
 Amniotic Fluid \_\_\_\_cc's (1<sup>st</sup> cc's separated Y/N)  CVS  Cord Blood  Products of Conception (specify) \_\_\_\_\_  
 Peripheral Blood  Tissue (specify) \_\_\_\_\_  Other \_\_\_\_\_

**PATIENT INFORMATION**

Name (Last, First): \_\_\_\_\_  
DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Medical Record Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ SS #: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Pregnant: Yes / No Gestational age: \_\_\_\_\_ Gender by U/S: Male / Female / Unknown Twins? Y/N  
Ethnicity:  Caucasian ( NW European  SW European )  Ashkenazi Jewish  Other Jewish  Hispanic  Asian  Afr. American  
 Native American  Other: \_\_\_\_\_

**REFERRING PHYSICIAN**

Name \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Name & Phone of person completing requisition: \_\_\_\_\_  Informed consent obtained (if appropriate)

**BILLING INFORMATION**

Bill:  Insurance  Referring Institution  Patient  Other Party

\* If Insurance will be billed, please attach a copy of current insurance card (front and back), which should include:  
Patient Name, Insurance Provider address & phone #, Policy #, Group #, Relationship to Patient

**TEST INDICATION**

ICD9 CODES (Required): \_\_\_\_\_

**Cyto/Molecular Tests**

-- CYTOGENETICS

- CHROMOSOME ANALYSIS/KARYOTYPE  
(Amniotic Fluid AFP done automatically unless otherwise specified)  No AFP
- Aneuvysion FISH (prenatal screen for X, Y, 13, 18, 21)
- FISH with Selected Probe (Specify) \_\_\_\_\_
- Save Cells Temporarily (Reason) \_\_\_\_\_

-- MOLECULAR (purple top EDTA required)

- Uniparental Disomy, Chrom # \_\_\_\_\_ (purple top tube)
- Thrombophilia Panel (purple top tube)
  - Factor V Leiden Mutation with reflex HR2
  - Prothrombin Mutation Analysis
  - MTHFR C677T Mutation Analysis
- Other \_\_\_\_\_

-- Additional tests on Amnio/CVS to be sent out:

- CF  CMV  Toxoplasmosis  Parvovirus
- Herpes I/II  RhD genotyping  Sickle Cell

**Ethnicity-Based Screening**

(5mL in purple top EDTA Tube)

- Cystic Fibrosis Carrier Screen (41 Mutations)
- Ashkenazi Jewish Panel (CF NOT included)
  - Bloom syndrome
  - Canavan Disease
  - Familial Dysautonomia
  - Tay-Sachs
  - Fanconi Anemia Type C
  - Gaucher Disease Type 1
  - Mucopolidosis Type IV
  - Niemann-Pick Type A & B

Complete Required Information:

\_\_\_\_ Patient/Couple is Pregnant  
\_\_\_\_ Family history of Disorder and/or Mutation  
Specify \_\_\_\_\_  
\_\_\_\_ Abnormal Ultrasound \_\_\_\_\_  
\_\_\_\_ Absence of Vas Deferens  
\_\_\_\_ Other Infertility

**Maternal Serum Screening**

(Red or Yellow Gel Separator Tube Required)

- Quad Check (AFP/UE3/hCG/Inhibin A)
  - Triple Check (AFP/UE3/hCG)
  - AFP Only
  - Repeat Test at This Laboratory
- Complete Required Information:**  
Patient Current Weight \_\_\_\_\_  
Insulin-Dependent Diabetic: \_\_\_\_ Yes \_\_\_\_ No  
Twin Pregnancy: \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ Unknown  
Previous Child with ONTD: \_\_\_\_ Yes \_\_\_\_ No  
Family History of ONTD: \_\_\_\_ Yes \_\_\_\_ No

**Gestational Age Dating:**

Last Menstrual Period \_\_\_\_\_  
Date of Ultrasound \_\_\_\_\_  
Gestational Age on that date \_\_\_\_\_  
EDC (By US Dating Only) \_\_\_\_\_  
By Physical Exam: \_\_\_\_\_ weeks  
Date of Exam \_\_\_\_\_