ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

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11643 - Lab Alliance of Cny I/F

113 innovation Lane
Liverpool, NY 13088

PATIENT NAME (Last) (FIRST) (M.I.)

PATIENT I.D. NUMBER | LAB I.D. NUMBER

BIRTHDATE (mo / day / yr) | SEX | REFERRING PHYSICIAN

PHONE/FAX RESULTS (Required) ❑ PHONE ❑ SECURE FAX
( ) number | contact name (last, first)

SPECIMEN COLLECTION
DATE: mo / day / yr TIME: ❑ AM ❑ PM

SPECIMEN TRANSPORT
❑ Refrigerated

SPECIMEN TYPE
❑ Serum

ATTENTION CLIENTS

The maternal screens listed below have separate specimen requirements. For tests requiring ultrasound information the NT may be obtained when the CRL is between 39mm and 85mm.
If the patient's NT measurement cannot be obtained, the first trimester or sequential screens cannot be ordered.

First Trimester Screen	Integrated Screen	Sequential Screen
Draw specimen between 11w 0d and 13w 6d gestation. (CRL=44-85mm)	Specimen #1: Draw specimen between 10w 3d and 13w 6d gestation. (CRL=34-85mm)	Specimen #1: Draw specimen between 11w 0d and 13w 6d gestation. (CRL=44-85mm)
Quad, Triple or AFP-Only Screens Draw specimen between 14w 0d and 24w 6d gestation	Specimen #2: Draw specimen between 15w 0d and 22w 6d gestation.	Specimen #2: Draw specimen between 15w 0d and 22w 6d gestation.

Maternal Serum Screening Assays (Reorder # 41130)

- ❑ 3000147 Maternal Serum Screen Integrated, Spcm1
- ❑ 3000149 Maternal Serum Screen Integrated, Spcm2
- ❑ 3000146 Maternal Serum Screen Sequential, Spcm1
- ❑ 3000148 Maternal Serum Screen Sequential, Spcm2
- ❑ 3000145 Maternal Serum Screen First Trimester
- ❑ 3000144 Maternal Serum Screen AFP
- ❑ 3000143 Maternal Serum Screen Quad

REQUIRED PATIENT INFORMATION:

A. Current weight
_____ lbs. *or* _____ kg.

B. Due date (EDD) _____
Determined by:
[ ] Last menstrual period, confirmed by US
[ ] Ultrasound [ ] Last menstrual period

C. Number of Fetus:
[ ] Singleton [ ] Twins [ ] Unknown
Check box if pregnancy is monochorionic [ ]

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

E. Was the patient diabetic at the time of conception?
[ ] No [ ] Yes

F. Is there a family history of neural tube defects (i.e., spina bifida, anencephaly, or encephalocele)?
[ ] No [ ] Yes
If yes, relationship of the affected individual to the fetus? _____

G. Has the patient had a previous pregnancy with a chromosome abnormality (i.e., 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 _____ years.

I. Has the patient taken valproic acid or carbamazepine during this pregnancy?
[ ] No [ ] Yes
If yes, specify drug _____

J. Is this a repeat sample?
[ ] No [ ] Yes [ ] Unknown

K. Does the patient currently smoke cigarettes?
[ ] No [ ] Yes [ ] Unknown

ADDITIONAL PATIENT INFORMATION (required for the First Trimester, Integrated-1 or Sequential-1 screens only)

Date of Ultrasound _____ Sonographer Name _____ Certification # _____

NT (mm) _____ CRL (mm) _____ Reading MD name _____ Certification # _____

If twins: Twin B NT (mm) _____ CRL (mm) _____

NEW YORK CLIENTS ONLY

Informed consent must be obtained before testing for New York clients only.
Maternal screening which includes NT, pregnancy associated plasma protein-A (PAPP-A), alpha fetoprotein (AFP, human chorionic gonadotropin (hCG), unconjugated estriol (uE3), and dimeric inhibin A (DIA) testing is offered to detect neural tube defects (spina bifida), chromosome disorders, incorrect dating, and adverse fetal outcomes. Neural tube defects occur when the brain and spine do not form properly. In 1 to 2 of 1000 pregnancies, conditions such as anencephaly or spina bifida occur. A normal test does not guarantee a normal baby. Most birth defects are not detected by maternal serum testing. An abnormal result means further testing is required. This may include a repeat screening test, ultrasound or amniocentesis. Counseling regarding the results will be provided by your physician. Maternal serum may be abnormal for may reasons including miscalculation of due date, twin pregnancy, vaginal bleeding or for no apparent reason.

I, _____,
certify that I have read this information and understand it. All of my questions have been answered satisfactorily. I freely and voluntarily consent to the test for NT/PAPP-A/AFP/hCG/uE3/DIA and give my permission to
Dr. _____ to send a sample of my blood to ARUP for testing. I authorize ARUP to report the test results to the above-named physician.

Patient signature _____ Date _____ Physician signature _____ Date _____

NUMBER OF SPECIMENS SUBMITTED _____

TOTAL NUMBER OF TESTS ORDERED _____

THIS BOX FOR ARUP LABORATORIES' USE ONLY

QTY _____ RT R F ID# _____
SER PLA WB URINE STOOL CSF S/P
TISSUE SST OTHER _____ WRAPPED

10/16