ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

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

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THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform maternal serum testing.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR MATERNAL SERUM TESTING

Patient Name _____

Patient Date of Birth _____

Patient MRN _____

Specimen Collection Date _____

Place barcode label here.

Patient's weight _____lbs OR _____kgs

Due date (EDD) _____ 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

Lab Use Only

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