

**WARDE MEDICAL LABORATORY**  
**PRENATAL GENETICS TEST REQUISITION**  
734-214-0300 800-760-9969 Fax: 734-214-0399

**Patient Information**

\*Name: \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient ID: \_\_\_\_\_ Specimen ID: \_\_\_\_\_

\*Referring Physician: \_\_\_\_\_ \* Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**\*Pregnancy Information**

Date of Ultrasound: \_\_\_\_\_ Gestational Age: \_\_\_\_\_

LMP: \_\_\_\_\_ G.A. determined by:  Ultrasound  
 LMP

EDC: \_\_\_\_\_ Parity: \_\_\_\_\_

\*Indication for Testing: \_\_\_\_\_

**Test Requests**

Chromosome Analysis, Amniotic Fluid (CHRAF): 20 mL Amniotic Fluid

**Alpha-Fetoprotein testing will be performed on all amniotic fluid specimens when the patient's gestational age is between 14-24 weeks. Abnormal AFP results will be reflexed to Acetylcholinesterase (AChE) and Fetal Hemoglobin assays.**

Alpha-Fetoprotein (AFP), Amniotic Fluid (AFPAF)

Acetylcholinesterase (AChE), Amniotic Fluid (ACEAF)

Fetal Hemoglobin, Amniotic Fluid (FHGBA)

Chromosome Analysis, Chorionic Villus Sample

Prenatal FISH for chromosomes 13, 18, 21, X, & Y (PNPF)

Chromosome Microarray Analysis (CGH)

Reflex to Chromosome Microarray Analysis if karyotype is normal (CGH)

Collection Date: \_\_\_\_\_ Time: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

\* Required Fields