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 (CHRAFSP): 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 (AFPAFSP)
☐ Acetylcholinesterase (AChE), Amniotic Fluid (ACEAFSP)
☐ Fetal Hemoglobin, Amniotic Fluid (FHGBSP)
☐ Chromosome Analysis, Chorionic Villus Sample
☐ Prenatal FISH for chromosomes 13, 18, 21, X, & Y (PNPFSP)
☐ Chromosome Microarray Analysis (CGH)
☐ Reflex to Chromosome Microarray Analysis if karyotype is normal (CGH)

Collection Date: _____ Time: _____

Additional Comments: _____

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* Required Fields