WARDE MEDICAL LABORATORY
PRENATAL GENETIC 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: _____

EDC: _____

Parity: _____

*Indication for Testing: _____

Test Requests

☐ Chromosome Analysis, Amniotic Fluid (CHRAF) 20mL 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)
☐ Prenatal Ploidy Assessment – FISH (PNPF)

Collection Date: _____ Time: _____

Additional Comments: _____

_____

* Required Fields