Warde
Medical Laboratory

# PRENATAL GENETICS TEST REQUISITION

Phone: 734-214-0300, 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
- ☐ Reflex to Chromosome Microarray Analysis if karyotype is normal (CGH)

**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)

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- ☐ 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)

Collection Date: _____ Time: _____

Required Fields*