

Center for Human Genetics Laboratory

University Hospitals of Cleveland/Case Western Reserve University
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Prenatal Genetic Requisition Form

Medical Record Number _____

PATIENT INFORMATION

Name (Last, First) _____ Phone (H) (____) _____ DOB ____/____/____

Address _____ (W) (____) _____ SS# ____-____-____

City/State/Zip _____

Ethnicity: Caucasian (NW European, SW European) Ashkenazi Other Jewish Hispanic Asian African American
 Native American Other _____

REFERRING PHYSICIAN

Name _____ Other Physician: _____

Phone: _____ Fax: _____ Genetic Counselor _____

BILLING INFORMATION

Bill: Insurance Referring Institution Patient Other Party

Please attach any appropriate billing information

SPECIMEN INFORMATION

Amniotic Fluid _____ cc's (1st cc's separated Y / N) (Gravida _____ Para _____) CVS

Products of Conception (specify) _____ Tissue (specify) _____ Cord Blood _____ cc Other (specify) _____

Date specimen collected _____ Time Collected _____ Where drawn (institution): _____

INDICATIONS FOR TESTING

Pregnant: Y / N Gestational age: _____ weeks Gender by U/S: Male / Fem / Unkn. Twins: Y / N

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Abnormal Triple Check
DS risk 1: _____
NTD risk 1: _____
MSAFP: (high) _____ MoM
Tri 18 risk 1: _____ | <input type="checkbox"/> Choroid Plexus Cyst
<input type="checkbox"/> Cystic Hygroma
<input type="checkbox"/> D&E
<input type="checkbox"/> Dandy Walker Malformation
<input type="checkbox"/> Diaphragmatic Hernia
<input type="checkbox"/> Duodenal Atresia
<input type="checkbox"/> Echogenic Bowel
<input type="checkbox"/> Echogenic Intracardiac Focus
<input type="checkbox"/> Encephalocele | <input type="checkbox"/> Gastroschisis / Omphalocele
<input type="checkbox"/> Heart Defect (list type below)
<input type="checkbox"/> Hydrocephalus
<input type="checkbox"/> Hydrops
<input type="checkbox"/> IUFD
<input type="checkbox"/> IUGR
<input type="checkbox"/> Microcephaly
<input type="checkbox"/> Neural tube defect (list below)
<input type="checkbox"/> Nuchal Translucency | <input type="checkbox"/> Oligo / Polyhydramnios
<input type="checkbox"/> Pyelectasis
<input type="checkbox"/> Recurrent Pregnancy Loss
<input type="checkbox"/> Short femur
<input type="checkbox"/> Single Umbilical Artery
<input type="checkbox"/> Spontaneous Abortion
<input type="checkbox"/> Translocation Carrier
<input type="checkbox"/> Ventriculomegaly |
|--|--|--|--|

Other _____

CHECK TEST REQUESTED

Chromosome Analysis / Karyotype (Amniotic fluid AFP done automatically unless otherwise specified) No AFP

FISH

- | | | |
|--|--|---|
| <input type="checkbox"/> AneuVysion (prenatal screen for abnormalities of X,Y,13,18,21) Need extra (>3cc) amniotic fluid | <input type="checkbox"/> DiGeorge/Velocardiofacial Syndrome
<input type="checkbox"/> Miller-Dieker Syndrome (Lissencephaly)
<input type="checkbox"/> STS (X-linked ichthyosis) | <input type="checkbox"/> Williams Syndrome
<input type="checkbox"/> Wolf-Hirschhorn (4p-) Syndrome
<input type="checkbox"/> Other _____ |
|--|--|---|

Molecular:

- | | | |
|---|--|---|
| <input type="checkbox"/> Cystic Fibrosis Carrier Screening (41 mutations)
<input type="checkbox"/> Family History of CF
<input type="checkbox"/> Patient/Couple is pregnant | <input type="checkbox"/> Factor V Leiden
<input type="checkbox"/> MTHFR
<input type="checkbox"/> Prothrombin 20210 | <input type="checkbox"/> Uniparental Disomy: chromosome # _____
<input type="checkbox"/> Other _____ |
|---|--|---|

ADDITIONAL TESTS REQUESTED ON AMNIOTIC FLUID/CVS CELLS (to be sent to another lab)

- | | | |
|--|---|--|
| <input type="checkbox"/> Cystic Fibrosis
<input type="checkbox"/> Cytomegalovirus (CMV)
<input type="checkbox"/> Herpes I/II | <input type="checkbox"/> Parvovirus
<input type="checkbox"/> RH-D genotyping (histocompatibility)
<input type="checkbox"/> Sickle Cell Analysis | <input type="checkbox"/> Toxoplasmosis
<input type="checkbox"/> Other _____ |
|--|---|--|

Special Instructions:

Save cells temporarily for the following reason: _____