ARUP LABORATORIES

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0116430000000006

500 Chipeta Way • Salt Lake City, Utah 84108-1221
(800) 522-2787 • www.aruplab.com

PATIENT NAME (LAST) (FIRST) (M.I.)

PLEASE TYPE OR PRINT

PATIENT I.D. NUMBER | LAB I.D. NUMBER

BIRTHDATE (mo / day / yr) | SEX | REFERRING PHYSICIAN

011643 (315) 461-3008
* Lab Alliance of Cny I/F
113 innovation Lane
Liverpool, NY 13088

DIAGNOSIS/CLINICAL INFORMATION

COMMENTS, SPECIAL INSTRUCTIONS

PHONE/FAX RESULTS ☐ PHONE ☐ SECURE FAX

( ) number — REQUIRED contact name (last, first)

OTHER TESTS ORDERED

Test Number — Test Name

SPECIMEN TRANSPORT

☐ Room Temperature ☐ Refrigerated ☐ Frozen

SPECIMEN COLLECTION

Date: mo / day / yr Time: ☐ AM ☐ PM

SPECIMEN TYPE

☐ SERUM ☐ PLASMA ☐ WHOLE BLOOD

☐ URINE: ☐ Random ☐ Timed — number of hours — total volume (mL)

☐ STOOL: ☐ Random ☐ Timed — number of hours — total volume (mL or g)

☐ CSF

☐ TISSUE: site — type

☐ OTHER:

**********NEW YORK PRENATAL TESTING**********

0080426 [] AFP/hCG (MATERNAL SERUM) 0080108 [] AFP/hCG/uE3 (MATERNAL SERUM) 0080269 [] AFP/hCG/uE3/DIA (MATERNAL SERUM)

THE FOLLOWING INFORMATION MUST BE COMPLETED AND ACCOMPANY SERUMFROM 5 mL CLOTTED BLOOD CLEARLY LABELED WITH NAME AND DATE OF DRAW.

Maternal Weight: _____ lbs. Date of LMP ____/____/____
Due Date (EDC) ____/____/____ Determined by ( ) Last Menstrual Period ( ) Ultrasound
Current pregnancy is ( ) singleton, ( ) twins, ( ) unknown Race: ( ) Caucasian ( ) Black ( ) Hispanic ( ) Other
Does the patient require insulin to control diabetes? ( ) Yes ( ) No
Has patient taken Valproic Acid or Carbamazepine during this pregnancy? ( ) Yes ( ) No If Yes, specify: _____
( ) Family history of neural tube defect, relation to fetus _____
Sample: ( ) Initial sample ( ) repeat sample. Is this an IVF pregnancy? If yes, age of egg donor: _____
Center to which abnormal results are to be called. _____

**********INFORMED CONSENT**********

Maternal serum testing which includes alpha-fetoprotein (AFP), humanchorionic gonadotropin (hCG), unconjugated estriol (uE3), and Dimeric Inhibin A (DIA) testing is offered to detect neural tube defects (spina bifida), chromosome disorders, incorrect dating, and adverse fetal outcomes. Neural tube defects occur when the brain and spine do not form properly. In 1 to 2 of 1000 pregnancies, conditions such as anencephaly or spina bifida occur. A normal test does not guarantee a normal baby. Most birth defects are not detected by mateal serum testing. An abnormal result means further testing is required. This may include a repeat screening test, ultrasound or amniocentesis. Counseling regarding the results will be provided by your physician. Maternal serum may be abnormal for many reasons including miscalculation of due date, twin pregnancy, vaginal bleeding or for no apparent reason. I, _____, certify that I have read this information and understand it. All of my questions have been answered satisfactorily. I free and voluntarily consent to the test for AFP/hCG/uE3/DIA and give permission to Dr. _____ to send a sample of my blood to ARUP for testing. I authorize ARUP to report the test results to the above-named physician.

_____ _____
Patient signature date Physician's signature date

REORDER FORM #32958 NYAFP 12/05

THIS BOX FOR ARUP USE ONLY

NUMBER OF SPECIMENS SUBMITTED _____ Qty _____ RT R F ID# _____

Ser Pla WB Urine Stool CSF S/P

TOTAL NUMBER OF TESTS ORDERED _____ Tissue SST Other _____ Wrapped