

Clinical Questionnaire for Reveal[®] SNP Microarray - Prenatal and POC

This form should be completed when Reveal[®] SNP Microarray - Prenatal or POC testing chromosome microarray testing is ordered. The form should be completed by the ordering physician's office and should accompany the specimen. Please call 800-345-GENE (4363) with any questions and ask to speak to a cytogenetics genetic counselor.

Patient's name: _____ Date of birth: _____

Name of person completing form: _____

Physician's signature: _____ GC/Physician's telephone: _____

Specimen Type: Amniotic Fluid Chorionic Villi Fetal Blood POC Fetal Gender: Male Female Unknown

Primary Indication: _____ Gestational Age: _____

G ___ P ___ ___ ___ Is this a twin/multiple pregnancy? Yes No If yes, check one: MZ ___ DZ ___ unknown ___

Was pregnancy achieved through ART? If so, how: egg donor sperm donor IVF ICSI

Ultrasound Abnormalities (if abnormal, please check and describe the abnormality in the space provided)

- | | |
|--------------------------------------|--------------------------------------|
| <input type="radio"/> Head | <input type="radio"/> Kidneys |
| <input type="radio"/> Brain | <input type="radio"/> Bladder |
| <input type="radio"/> Face | <input type="radio"/> Genitalia |
| <input type="radio"/> Spine | <input type="radio"/> Extremities |
| <input type="radio"/> Neck/Skin | <input type="radio"/> Skeleton |
| <input type="radio"/> Thorax | <input type="radio"/> Amniotic Fluid |
| <input type="radio"/> Heart | <input type="radio"/> Cord |
| <input type="radio"/> Abdominal Wall | <input type="radio"/> Fetal Growth |
| <input type="radio"/> GI-tract | <input type="radio"/> Movement |

If other ultrasound abnormality, please describe: _____

Significant Pregnancy History

Medications/Exposures Yes No If yes, please describe: _____

Maternal Illness/Infection Yes No If yes, please describe: _____

Abnormal Maternal Serum Screening Yes No If yes, indicate results: _____

Chromosome results (if known)

Current pregnancy: _____ Date performed: _____ Lab: _____

Previous pregnancy: _____ Date performed: _____ Lab: _____

Parental Chromosomes: Maternal _____ Date performed: _____ Lab: _____

Paternal _____ Date performed: _____ Lab: _____

Significant Family History:

Maternal: _____

Paternal: _____

Other Children: _____

Prenatal SNP microarray can detect identity by descent. Are the parents known to be related? If so, how: _____

Additional copies of this form can be printed from our website: www.integratedgenetics.com

