UNIVERSITY OF CONNECTICUT HEALTH CENTER
Department of Pathology and Laboratory Medicine
Human Genetics Laboratory Requisition HCH-499R
Butler Building 5
263 Farmington Avenue, Farmington, CT 06030-6140
Licences CT HP0213 CLIA 07D0092519
Laboratory Phone 860-679-4806 Fax 860-679-4469
Genetic Counselors 860-523-6464

REQUISITION DATE _____

Requesting Physician (please print) _____

Requesting Physician signature _____

Clinic Location (PLEASE CIRCLE)

Outside Physician
CM5 MFM EHOOB
Day Kimball HartfordHosp Rockville

Physician Phone _____
Physician Fax _____

PATIENT NAME _____

ADDRESS _____

_____

_____

HOME PHONE _____

MRN (TO#) _____

Collection Site _____

Collection Date _____ Collection time _____

DIAGNOSIS (check all applicable and add if necessary)

☐	V22.0	SUPERVISION OF NORMAL FIRST PREGNANCY	☐	V19.8	FAMILY HISTORY OF OTHER CONDITIONS
☐	V22.1	SUPERVISION OF OTHER NORMAL PREGNANCY	☐	793.99	ABNORMAL ULTRASOUND
☐	659.63	OTHER ADVANCED MATERNAL AGE, ANTEPARTEM CONDITION	☐	V19.5	FAMILY HISTORY OF ONTD
☐	V28.9	UNSPECIFIED ANTENATAL SCREENING OF MOTHER	☐		OTHER (Specify)

CLINICAL INFORMATION

Date of Birth _____ **Weight** _____ Lbs. On _____

Race/Ethnicity Caucasian Black Hispanic Other (specify) _____

Was the patient insulin-dependent diabetic prior to pregnancy? Yes No **Patient smokes cigarettes?** Yes No

Singleton? Yes No If not, number of fetuses: _____ **Chorionicity:** mono di unknown

Family history of ONTD: Yes No If yes, type and relation _____

Prev pregnancy with: Trisomy 21 Trisomy 18 Trisomy 13 Other (specify) _____

IVF procedure date: _____ **Egg donor date of birth:** _____

FIRST TRIMESTER TEST REQUESTED

☐ PAPP-A, HCG, with NT

Please provide ultrasound report, OR, complete the following:

Sonographer: _____ NTQR P# _____

MFM Physician: _____ NTQR P# _____

LMP date: _____

Ultrasound Date: _____ wks _____ days _____

Gestational Age _____ wks _____ days

CRL _____(mm) NT _____(mm) (Twin A)

CRL _____(mm) NT _____(mm) (Twin B)

SECOND TRIMESTER TEST REQUESTED

☐ AFP, HCG, UE3, INH-A (QUAD test)
☐ AFP only

LMP _____ **EDC** _____

Date of Ultrasound _____

Gestational Age _____wks _____days

Date of Ultrasound _____

Gestational Age _____wks _____days

Did this patient previously receive first trimester screening?
Yes No If YES, please attach copy of lab results

FOR LAB USE ONLY

SAMPLE NUMBER _____ INTERNAL NUMBER _____ DATE RECEIVED _____

REQ VERIFIED PT INFO MD INFO DIAGNOSIS CLINICAL HISTORY US 1st TRI

Laboratory testing will not be performed unless all required information is provided on requisition (Attach reports as necessary)

White - Dept copy Pink - Patient chart Requisition HCH-