Ambry Genetics®
A Konica Minolta Company

ExomeNext® Prenatal Form
(Please submit with ExomeNext Test Requisition Form)

PATIENT INFORMATION

Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Today's Date (MM/DD/YY)

PLEASE PROVIDE A BRIEF SYNOPSIS OF THE ULTRASOUND FINDINGS

Please also attach clinical notes

CLINICAL DETAILS

LMP: _____ EDD/EDC:_____ Multiple SABs: ☐ Yes ☐ No

Egg donor used: ☐ Yes ☐ No Sperm donor used: ☐ Yes ☐ No Previous affected child/pregnancy: ☐ Yes ☐ No

Imaging studies

☐ Ultrasound ☐ Fetal echocardiogram ☐ MRI

Please describe any abnormalities: _____

Lagging growth/IUGR: ☐ Yes ☐ No Suspected overgrowth: ☐ Yes ☐ No

Ultrasound Measurements: BPD: _____ NT: _____ CRL: _____

Prenatal Screening Performed

Maternal Serum Screening: ☐ Normal ☐ Abnormal (describe):_____

NonInvasive Prenatal Screening: ☐ Normal ☐ Abnormal (describe):_____

Genetic Testing

Chromosomes/Karyotype:

☐ Chromsome Microarray Analysis (CMA) Results:_____

☐ Karyptype Results:_____

☐ Other:_____

SECONDARY FINDINGS REPORT

For ongoing pregnancies, in addition to the ACMG Secondary Findings Recommended List, the Childhood Onset Diseases Secondary Findings are included at no additional charge. A complete list of genes included in the Childhood Onset Diseases category can be made available upon request.

Childhood Onset Disease:

☐ Yes; I would like to include Childhood onset secondary findings.

☐ No; I choose to decline Childhood onset secondary findings.

Medical Professional Name:

Medical Professional Signature: **Date:**

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