

PATIENT INFORMATION

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

Fetal Sex: Female Male Unknown/Ambiguous

Prenatal Screening Performed

Maternal Serum Screening: Normal Abnormal (describe): _____

NonInvasive Prenatal Screening: Normal Abnormal (describe): _____

Genetic Testing

Chromosomes/Karyotype:

Chromosome Microarray Analysis (CMA) Results: _____

Karyotype 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:** _____