HEALTHLAB

HealthLab
25 North Winfield Road
Winfield, Illinois 60190
Phone: 630.933.2633
Fax: 630.933.5292

Chromosome Studies, Amniotic Fluid

Name: _____ Father's name: _____

Date of birth: _____ Address: _____ City: _____

Telephone: (day): _____ (evening): _____ Zip: _____

Obstetrician: _____ Telephone: _____

Hospital: _____

Date of last menstrual period: _____

Date of amniocentesis: _____ Blood type and Rh: _____

Number of previous pregnancies: _____

Living children: _____ Stillbirths: _____ Miscarriages: _____

Induced abortions: _____ Children who died: _____

Fetal age (Ultrasound measurement): _____

Weeks after LMP: _____

History of hereditary problem or birth defects in family:

_____

_____

Reason for amniocentesis: _____

_____

_____
PATIENT'S SIGNATURE

Please complete all information and attach this form to the test requisition.
Send both with the specimen in the transport bag to the laboratory.