REQUEST FORM

Sample Barcode

Non-invasive Prenatal Genetic Testing for Fetal Chromosomal Aneuploidies

PATIENT INFORMATION

First Name(Given Name) **IN CAPITAL**

Last Name(Surname) **IN CAPITAL**

DATE OF BIRTH DD MM YYYY

ID/Passport No.

Nationality

Reference No.

Weight(kg) Height(cm)

Phone

Address

HISTORY

Gravida(n) Parity(n)

Date of Last Delivery/Abortion DD MM YYYY

Spontaneous Abortions

Terminations of Pregnancies

Molar pregnancies

Ectopic pregnancies

Previous pregnancies affected by chromosomal or genetic disease
No. Yes, name of the condition: ____________________

Family history of genetic diseases
No. Yes, name of disease: ______________________________

Is the pregnant woman carrier of a genetic condition?
No. Yes, name of the condition: ____________________

CURRENT PREGNANCY

LMP DD MM YYYY

Working EDC (by LMP/USG) DD MM YYYY

Gestational Week (w+d)

IVF
YES
NO

USG
Date:
Singleton
Multiple pregnancy
DCDA
MCDA
MCMA
Not done

Structure
Normal
Abnormal
Please specify_____________

Prior Down Syndrome Screening Test
No
Yes, the estimated risk of T21: 1/____, T18: 1/___, T13:_____

Type of test:
1st Trimester NT+Bch
1st Trimester NT only
1st Trimester Bch only
2nd Bch only
1st and 2nd Trimester integrated
2nd Trimester USG only
Other, please specify____________

REQUESTING DOCTOR INFORMATION

NAME **in CAPITAL**: DR.

Hospital/Clinic:

Address:

Requesting doctor's email(if any):

Doctor's signature

SAMPLE INFORMATION

Sample type
Extracted DNA
Whole blood
Plasma

Sample packing
Streck tube
Dry ice
Blue ice

Blood collection
Date:
Time:

Centrifugation
Date:
Time:

DNA extraction
Date:
Time:

TO BE COMPLETED BY LAB PERSONNEL

Received Date: DD MM YYYY
Time: **Signature:**