eurofins | GENOMA® Molecular Genetics Laboratories Group

374586 | Eurofins Biomnis

TEST REQUEST AND PATIENT CONSENT FORM

PATIENT DETAILS

Name_____Surname_____

Date of birth_____ Place of birth_____

Address: _____

_____

Date of blood withdraw _____

Gynecologist name:_____

Address:_____

_____

Phone no.: _____

E-mail: _____

Protocol no. (internal use only): _____

ORDERING LABORATORY / CLINICIAN

Name / Stamp

PATIENT MEDICAL HISTORY

PREGNANCY HISTORY

Patient current weight Kg _____ Patient height_____

Gestational age at draw _____week + days _____

Gestational age calculated by:

☐ Ultrasound; ☐ last menstrual period; ☐ IVF treatment

Twin pregnancy? ☐ Yes; ☐ NO

IVF Pregnancy? ☐ Yes; ☐ NO

☐ Homologous pregnancy; ☐ Heterologous Pregnancy

☐ Embryo donation ☐ Eggs donation ☐ Sperm donation

INDICATION FOR TESTING

☐ Advanced maternal age; ☐ Advanced paternal age;

☐ Partner carrier of a genetic disorder: ☐ Male ☐ Female

☐ Specify disorder: _____

☐ Specify gene and mutation: _____

☐ Parental anxiety (low-risk) _____

☐ Abnormal ultrasound (describe): _____

☐ Other indication _____ ☐ None

TEST RREQUESTED, please tick all that apply

☐ PrenatalSAFE® 3 test (for chromosomes 21, 18,13 only)

☐ PrenatalSAFE® 5 test (for chromosomes 21, 18, 13, X, Y)

☐ PrenatalSAFE® Plus test (for chromosome 21, 18, 13, X, Y) + ☐ Panel 6 Microdeletion ☐ Trisomies 9 and 16 option

☐ PrenatalSAFE® Karyo test (genome-wide NIPT that provides karyotype-level insight)

☐ PrenatalSAFE® Karyo Plus test (genome-wide NIPT that provides karyotype-level insight + Panel 9 Microdeletions)

☐ GeneSAFE™ Inherited ☐ GeneSAFE™ *de novo* ☐ GeneSAFE™ Complete (Inherited + *de novo*)

☐ PrenatalSAFE® COMPLETE (PrenatalSAFE® Karyo + GeneSAFE™ Complete)

☐ PrenatalSAFE® COMPLETE Plus (PrenatalSAFE® Karyo Plus + GeneSAFE™ Complete)

Do you wish to know the fetal gender? ☐ Yes; ☐ NO Is it a redraw? ☐ Yes; ☐ NO

PATIENT CONSENT

I consent to the test(s) I have chosen and confirm that I have been informed about the purpose, scope, and limitations of the test by my healthcare provider. I understand that the test is a screen for selected abnormalities; that the result should be reviewed by my healthcare provider. I have had the opportunity to ask questions and understand that I can request further information or appropriate counselling. I consent to the use of the leftover specimen and health information as described in the Patient Test Information Document.

_____ _____ _____

Patient Name Signature Date

REPORTING PREFERENCES

☐ PHYSICIAN / LABORATORY

☐ E-mail _____

☐ On-Line ☐ Post

In order to activate the on-line reporting option, you need to provide us

Username:_____Password:_____

_____ _____

SIGNATURE DATE