eurofins | Biomnis

Eurofins Biomnis Pre-Natal Genetic Test Request, Information & Consent

PATIENT DETAILS

Surname: ___________________________________

Forename: __________________________________

Date of Birth: ______/______/_______

Sex: Male ☐ Female ☐

Hospital/Clinic No.: ___________________________

Laboratory No.: ______________________________

Ward: ______________________________________

Physician: ___________________________________

REQUESTING HOSPITAL/ CLINIC DETAILS

Hospital / Clinic Name:

____

Department:

____

Address: ____________________________________

____

____

Phone: __________________Fax: ______________

PLEASE REMEMBER ALWAYS TO COMPLETE THE INFORMED CONSENT SECTION

SAMPLE DETAILS

Specimen Collection Date: _____/_____/______/ Specimen Type (Amniotic Fluid): ______________________

Other Sample Type: ____

TEST INFORMATION

PRE-NATAL GENETICS

TEST NAME	CODE	SELECT
QF PCR & Karyotyping (Amniotic Fluid)	ANEUP & KARPN	☐
Chromosome Analysis – Placenta/CVS	KARPL	☐

OTHER TESTS REQUIRED:

____

____

____

INDICATIONS / SUSPECTED CONDITIONS / PREGNANCY INFORMATION

PLEASE DESCRIBE INDICATIONS/ SUSPECTED CONDITION: ____

____

____

PREGNANCY INFORMATION:

- LMP: _____/_____/_______ EDD: _____/_____/_______
  Day / Month / Year Day / Month / Year

- Scan Date: _____/_____/______ i.e. Gestational Age _____/______ of amenorrhea on scan day
  Day / Month / Year Weeks / Days

DOWN SYNDROME RISK EVALUATION RESULTS (IF AVAILABLE):______________________________

____

FAMILY HISTORY OF CHROMOSOME ABNORMALITIES (DETAIL): __________________________

____

____

eurofins | Biomnis

Eurofins Biomnis Pre-Natal Genetic Test Request, Information & Consent

PATIENT HISTORY

MEDICAL HISTORY: ____
____
____
____

SURGICAL HISTORY: ____
____
____
____

OBSTETRIC HISTORY: ____
____
____
____

INFORMED CONSENT SECTION

- **Patient or Guardian:**

I/we the undersigned confirm that I/we have been fully informed by the Doctor/Pathologist/ Geneticist ______________________________ regarding cytogenetic and/or molecular genetic tests that will be performed on cells and/or DNA extracted from my/our child's blood and/or tissue to:

- confirm or exclude the diagnosis of or a predisposition to a genetic disease.
- determine heterozygote status with a view to obtaining genetic counselling.
- examine gene locus/loci.

I/we give my/our consent to such testing and confirm that I/we have received all the necessary information according to the law.

Patient/Guardian Signature: ______________________________ **Date:** ______/_______/_______

- **Doctor/ Pathologist/Genetic Consultant:**

The Cytogenetic and/or molecular genetic test information is to be given by the Clinical Pathologist prescribing the test, or by the Physician collecting the sample. All relevant issues regarding the involved pathology etiology, development, prognosis and potential treatment must have been raised by the Genetic consultant or the Physician and clearly understood by the patient. All information associated with the patient file will be retained by Eurofins Biomnis. The result must be reported to the Physician only.

Doctor/Pathologist Signature: _______________________________ **Date:** _____/______/_______