PRENATAL TESTING REQUEST FORM

Adelaide Fertility Centre T/A - A.P.A. 1177

repromed Fertility Specialists.

nest

MEDICARE NUMBER:

RCPA The Royal College of Pathologists of Australasia

NATA WORLD RECOGNISED ACCREDITATION

RCPA/NATA ACCREDITATION NO. 2774

180 Fullarton Road Dulwich SA 5065 TEL **1800 874 971** FAX **(08) 8333 8188** A.P.L. 38733 **REQUEST FORM**

APP - Dr. J. Woolcock; Prof. K. Tremellen

PATIENT DETAILS

PATIENT LAST NAME | GIVEN NAME (INCLUDING MIDDLE INITIAL) | SEX | DATE OF BIRTH | CLIENT REF. NO.

PATIENT ADDRESS | TELEPHONE HOME | WORK

MOBILE | REQUEST NO.

TESTS REQUESTED

SINGLETON

- **NEST** Includes Chromosomes 21, 18, 13
- **NEST** Includes Chromosomes 21, 18, 13 **plus Sex Chromosome aneuploidies**
- **FETAL GENDER** printed on report **(Note: the box above must be selected)**
- **FIRST TRIMESTER BIOMARKERS** (freeBhCG, PAPP_A, PLGF)

TWINS

- **NEST** Includes Chromosomes 21, 18, 13
- **PRESENCE OF Y CHROMOSOME** printed on report

Interpretation
No Y chromosome = 2 Female twins
Yes Y chromosome + Either 1 or 2 male twins

- **FIRST TRIMESTER BIOMARKERS** (freeBhCG, PAPP_A, PLGF)

CLINICAL NOTES

- Self Determined
- Weight (kg)
- Height (cm)

ESSENTIAL INFORMATION Gestational Age

- LMP / / **OR**
- EDD / / **OR**
- BY SCAN wks days
- Scan Date / /

OTHER INFO

- IVF conceived
- Donor
- Age of Donor yrs

COMMENTS

ESSENTIAL INFORMATION FOR TESTING FIRST TRIMESTER BIOMARKERS

What is your ethnic origin?

- Afro-Caribbean (African, Caribbean, African-American)
- Asian (Indian, Pakistani, Bangladeshi, Sri Lankan, Afghani)
- Caucasian (European, Middle Eastern, North African, Hispanic)
- Oriental (Chinese, Korean, Japanese, Malaysian, Indonesian)
- Other (mixed race)

Gestation Age

CRL mm Scan date / /

No. of Fetuses Chorionicity

Have you had a previous Trisomy pregnancy? Yes No

If Yes, which Trisomy T21 T18 T13

Please tick ✔ if the following applies:

Have you been a smoker in this pregnancy?

Do you have diabetes?

Do you have any of the following? Hypertension Systemic Lupus Antiphospholipid syndrome

Have you had a previous pregnancy with pre-eclampsia?

Are you taking aspirin in this pregnancy?

Did your mother have pre-clampsia in her pregnancy with you?

Hospital status of patient at specimen collection or date of service	YES	NO
Private patient in a private hospital or approved day hospital facility		
Private patient in a recognised hospital		
Public patient in a recognised hospital		
Outpatient of a recognised hospital		

REQUESTING DOCTOR (PROVIDER NUMBER, SURNAME & INITIALS, ADDRESS)

COPY REPORTS TO

DOCTOR'S SIGNATURE AND REQUEST DATE

X X / /

Your treating practitioner has recommended that you use Repromed Laboratories i.e. NEST. You are free to choose your own pathology provider. However, if your doctor has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your doctor.

Medicare Assignment
(Section 20A of the Health Insurance Act 1973). I offer to assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner.

Informed Consent My signature on this form indicates that I have read or have had read to me the information about the nest test and I consent to having the test performed on my blood. I understand that this test is a screening test for selected abnormalities of chromosomes 21, 18 and 13. In addition, I understand that I can also request to have the sex chromosomes tested which can screen for less serious selected abnormalities of the sex chromosomes and I can also elect to have fetal gender reported. I have had the opportunity to ask questions and discuss limitations of the test with my health care provider or someone that my healthcare provider has designated. I understand that should my test come back with a 'high probability' finding that this result should be confirmed by further testing (chorionic villus sampling or amniocentesis). I also understand that sometimes this testing is unable to provide a result due to biological factors and in this instance I will be provided with a refund.

ATTENTION: DOCTORS/NURSES/PHLEBOTOMISTS

DECLARATION: I certify that I collected the accompanying sample from the above patient whose identity was confirmed by enquiry and/or examination of their name band and that I labelled the sample immediately following collection.

COLLECTOR'S NAME DATE / /

COLLECTOR'S SIGNATURE TIME

PATIENT CONFIRMATION OF CORRECT PERSONAL DETAILS LISTED ON FORM AND INFORMED CONSENT FOR NEST TESTING (read informed consent section above).

X X / /

PATIENT'S SIGNATURE DATE

PRACTITIONER'S USE ONLY (REASON PATIENT CANNOT SIGN)

Patients should be aware that they will be invoiced. For prenatal cytogenetic testing patients should note that results will be issued to themselves or their partner unless we are otherwise instructed. FTS is accredited for compliance with NPAAC Standards and ISO 15189.

Privacy Note: The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of government health programs, and may be used to update enrolment records. Its collection is authorised by provisions of the *Health Insurance Act 1973*. The information may be disclosed to the Department of Health and Ageing or to a person in the medical practice associated with this claim, or as authorised/required by the law.

MON0006_A