Adelaide Fertility Centre T/A - A.P.A. 1071

repromed Fertility Specialists.

nest

MEDICARE NUMBER:

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

APP - Dr. C. Kirby; Prof. K. Tremellen

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

PATIENT ADDRESS | POSTCODE | TELEPHONE (HOME: WORK:) | MOBILE | REQUEST NO.

**TESTS REQUESTED**

| | Singleton | Twins |
|---|---|---|
| **NEST** Includes Chromosomes 21, 18, 13 | ☐ | ☐ |
| **NEST** inc. Chromosomes 21, 18, 13 plus Sex Chromosomes aneuploidies option | ☐ | n/a |
| **Fetal gender reported** (for singleton pregnancy must select sex aneuploidy option) | ☐ | ☐ |
| **FIRST TRIMESTER BIOMARKERS** (free ßhCG, PAPP-A, PLGF) | ☐ | |

**CLINICAL NOTES** ☐ Self Determined

**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 _____

| 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 | ☐ | ☐ |

**DOCTOR'S SIGNATURE AND REQUEST DATE**

X _____ X ___/___/___

**COPY REPORTS TO**

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

**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 risk' 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.

**ESSENTIAL INFORMATION**

GESTATION BY SCAN ☐ weeks ☐ days

IVF CONCEIVED ☐ yes ☐ no

**MEDICARE ASSIGNMENT & 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)

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**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.

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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. **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.** FTS is accredited for compliance with NPAAC Standards and ISO 15189.