

# PRENATAL TESTING REQUEST FORM

Monash IVF Pty Ltd - A.P.A. 1177

MEDICARE NUMBER:



TO MAKE AN APPOINTMENT REFER TO INFORMATION OVERLEAF

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

RCPA/NATA ACCREDITATION NO. 2774  
APP - Dr. J. Woolcock; Prof. K. Tremellen

## PATIENT DETAILS

PATIENT LAST NAME	GIVEN NAME (INCLUDING MIDDLE INITIAL)	SEX	DATE OF BIRTH	CLIENT REF. NO.
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PATIENT ADDRESS	TELEPHONE	HOME	REQUEST NO.	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
CLINICAL NOTES	WEIGHT (KG)	HEIGHT (CM)		
<input type="checkbox"/> SELF DETERMINED				

## TEST REQUESTED - NIPT

VIABILITY ULTRASOUND

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SINGLETON

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NEST All chromosomes

NEST All chromosomes **plus SCA [Sex Chromosome Aneuploidies (SCA)]**

FETAL GENDER printed on report  
**(Note: the SCA option must be selected)**

**ESSENTIAL INFORMATION** Gestational Age

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LMP \_\_\_\_\_ OR EDD \_\_\_\_\_ OR

BY SCAN Scan Date \_\_\_\_\_  wks  days

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**OTHER INFO**  IVF conceived  Donor  Age of Donor  yrs

## COMMENTS

## TEST REQUESTED - FIRST TRIMESTER BIOMARKERS

SINGLETON

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FIRST TRIMESTER BIOMARKERS  
(freeBhCG, PAPP\_A, PLGF)

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**ESSENTIAL INFORMATION** Gestational Age

CRL \_\_\_\_\_ mm Scan date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have you had a previous Trisomy pregnancy?  Yes  No

If Yes, which Trisomy  T21  T18  T13

**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)

**Please tick ✓ if the following applies:**

Have you been a smoker in this pregnancy?

Do you have diabetes?

Are you taking aspirin in this pregnancy?

Have you had a previous pregnancy with pre-eclampsia?

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

**Do you have any of the following?**

Hypertension

Systemic Lupus

Antiphospholipid syndrome

<b>Hospital status of patient at specimen collection or date of service</b>	YES	NO
Private patient in a private hospital or approved day hospital facility	<input type="checkbox"/>	<input type="checkbox"/>
Private patient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>
Public patient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient of a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>

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

## COPY REPORTS TO

## DOCTOR'S SIGNATURE AND REQUEST DATE

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

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 1-22. 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).**

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**PRACTITIONER'S USE ONLY (REASON PATIENT CANNOT SIGN)**

## NEST BLOOD COLLECTION

### General information:

- Please make an appointment by phoning 8333 8172
- Appointments may be made at:  
Repromed Dulwich: 180 Fullarton Rd, Dulwich SA 5065  
Repromed Mawson Lakes: 8B Light Common, Mawson Lakes, SA 5095
- Upon arrival please report to the reception desk and notify them that you are here for a NEST blood test
- You will be asked to take a seat in the waiting room and a staff member will collect your blood as soon as possible.
- No fasting is required for your NEST blood test

### NOTE:

For your ultrasound please present with a **FULL BLADDER**, ie: you should not pass urine for 1 hour before the examination, then drink 2 glasses of **NON GASEOUS FLUID 1 hour** before the examination. Your Sonographer may advise you that a transvaginal scan may be required, this will only be performed with your consent.

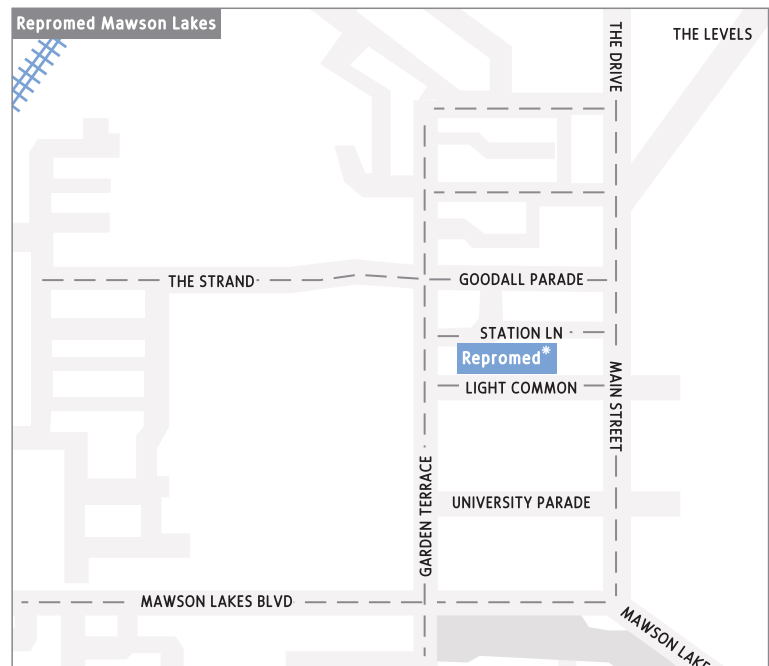
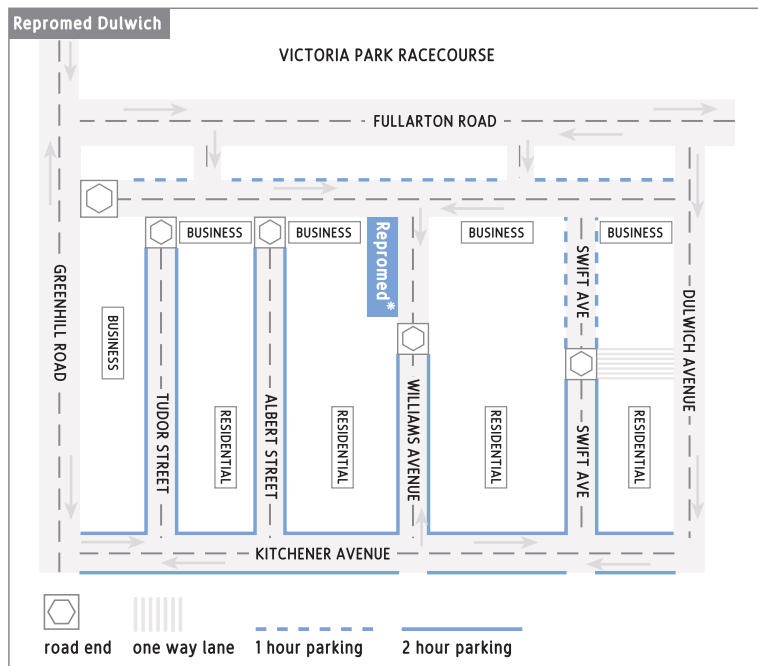
## NEST BLOOD COLLECTION AND ULTRASOUND SERVICE

### General information:

- **By appointment only**, please make an appointment by phoning 8333 8172
- Appointments may be made at:  
Repromed Dulwich: 180 Fullarton Road, Dulwich SA 5065
- Upon arrival please report to the reception desk and notify them that you are here for a nest blood test and ultrasound
- You will be asked to take a seat in the waiting room and a staff member will attend to you as soon as possible.
- No fasting is required for your NEST blood test

### PATIENT ADVISORY STATEMENT:

You have been referred by your doctor to Repromed to ensure you receive the highest quality personalised imaging. You may however consider alternative options with your doctor.



## APPOINTMENT DETAILS

repromed Fertility Specialists. 180 Fullarton Road Dulwich SA 5065  
TEL 1800 874 971 FAX (08) 8333 8188



MEDICARE NUMBER:

DATE OF APPOINTMENT

TIME

LOCATION (TICK ONE)

- Dulwich
- Mawson Lakes

TEST REQUIRED (TICK ONE)

- NEST blood test only
- NEST blood test and ultrasound