

# PRENATAL TESTING REQUEST FORM

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

MEDICARE NUMBER:



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="text"/>	<input type="text"/>	<input type="text"/>		

SELF DETERMINED

## TEST REQUESTED - NIPT

<b>SINGLETON</b>	<b>TWINS</b>
NEST Chromosomes 21, 18, 13 <input type="checkbox"/>	NEST Chromosomes 21, 18, 13 <input type="checkbox"/>
NEST Chromosomes 21, 18, 13 plus Sex Chromosome Aneuploidies (SCA) <input type="checkbox"/>	PRESENCE OF Y CHROMOSOME <input type="checkbox"/>
FETAL GENDER printed on report (Note: the SCA option must be selected) <input type="checkbox"/>	<p><b>Interpretation</b>                  No Y chromosome = 2 Female twins                  Yes Y chromosome = Either 1 or 2 male twins</p>

**ESSENTIAL INFORMATION** Gestational Age

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

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

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

## COMMENTS

## TEST REQUESTED - FIRST TRIMESTER BIOMARKERS

<b>SINGLETON</b>	<b>TWINS</b>
FIRST TRIMESTER BIOMARKERS (freeBhCG, PAPP_A, PLGF) <input type="checkbox"/>	FIRST TRIMESTER BIOMARKERS (freeBhCG, PAPP_A, PLGF) <input type="checkbox"/>

**ESSENTIAL INFORMATION** Gestational 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

**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 21, 18 and 13. In addition, I understand that I can also elect 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)**