PRENATAL TESTING REQUEST FORM

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

MEDICARE NUMBER:

nest | western ultrasound for women | repromed Fertility Specialists. | RCPA The Royal College of Pathologists of Australasia | NATA WORLD RECOGNISED ACCREDITATION

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; Dr. T. Hardy

PATIENT DETAILS

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

PATIENT ADDRESS | TELEPHONE HOME | REQUEST NO.

CLINICAL NOTES | WEIGHT (KG) | HEIGHT (CM)

SELF DETERMINED ☐

TEST REQUESTED

VIABILITY ULTRASOUND SINGLETON + nest+

- **NEST** All chromosomes* ☐
- **NEST** All chromosomes* **plus Sex Chromosome Aneuploidies (SCA)** ☐
- **FETAL GENDER** printed on report **(Note: the SCA option must be selected)** ☐
- **FIRST TRIMESTER BIOMARKERS** (freeBhCG, PAPP_A, PLGF) ☐

VIABILITY ULTRASOUND SINGLETON nest

- **NEST** Nest Chromosomes 21, 18, 13 ☐
- **NEST** Chromosomes 21, 18, 13 **plus Sex Chromosome Aneuploidies (SCA)** ☐
- **FETAL GENDER** printed on report **(Note: the SCA option must be selected)** ☐
- **FIRST TRIMESTER BIOMARKERS** (freeBhCG, PAPP_A, PLGF) ☐

VIABILITY ULTRASOUND TWINS nest

- **NEST** 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) ☐

ESSENTIAL INFORMATION
Gestational Age

☐ LMP _____

OR

☐ EDD _____

OR

☐ BY SCAN

Scan Date _____

_____ days _____ wks

* Please note: screening for ALL OTHER CHROMOSOMES is not currently NATA accredited

COMMENTS

DOCTOR'S SIGNATURE AND REQUEST DATE

X _____ DATE 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 1-22 or 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)

WANEST+_2021

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.

INFORMATION STATEMENT

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repromed Fertility Specialists.

nest

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INFORMATION STATEMENT

NEST BLOOD COLLECTION

General information:

- No fasting is required for your NEST blood test
- Appointments may be made at:

Western Ultrasound for Women MURDOCH.
Tel 9310 1888
Suite 62, 4th Floor, SJOG Wexford Medical Centre
3 Barry Marshall Parade, Murdoch WA 6150

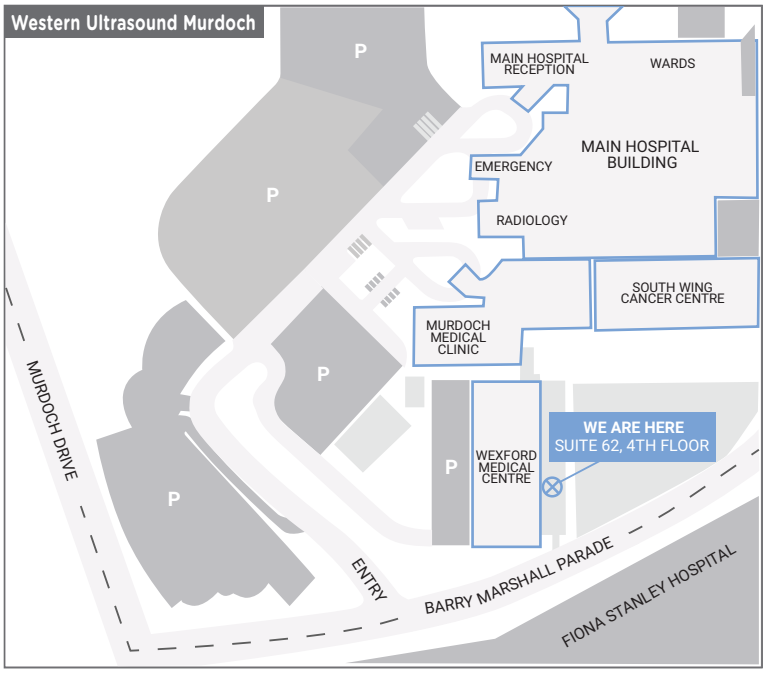
Western Ultrasound for Women WEST LEEDERVILLE.
Tel. 9388 1340
1/160a Cambridge St, West Leederville WA, 6007

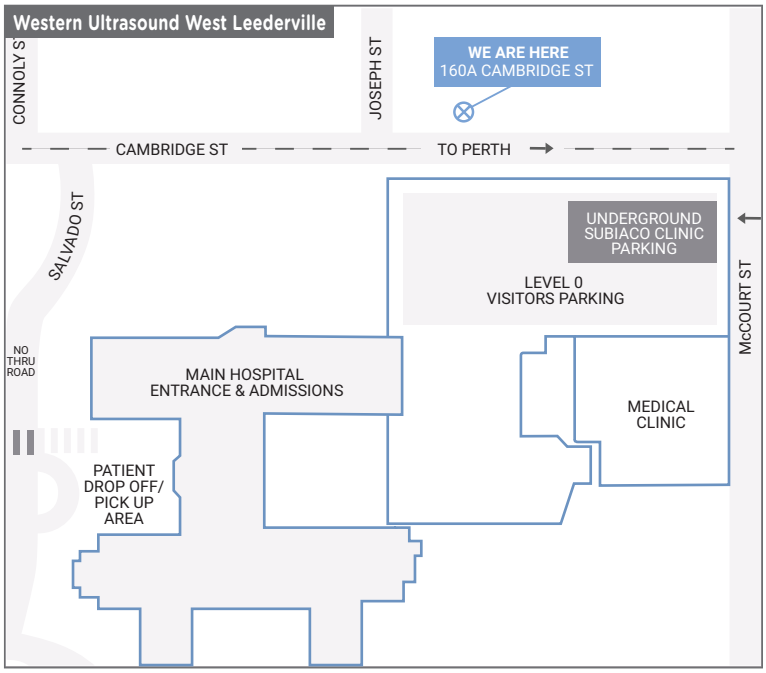
NOTE:

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.

PATIENT ADVISORY STATEMENT:

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





APPOINTMENT DETAILS

western ultrasound for women

MURDOCH **9310 1888**
WEST LEEDERVILLE **9388 1340**

nest

MEDICARE NUMBER:

DATE OF APPOINTMENT

TIME

LOCATION (TICK ONE)

- ☐ Murdoch
- ☐ West Leederville

TEST REQUIRED (TICK ONE)

- ☐ NEST blood test only
- ☐ NEST blood test and ultrasound