PRENATAL TESTING REQUEST FORM

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

MEDICARE NUMBER:

nest+

repromed Fertility Specialists.

RCPA The Royal College of Pathologists of Australasia

NATA WORLD RECOGNISED ACCREDITATION

RCPA/NATA ACCREDITATION NO. 2774*

APP - Dr. J. Woolcock; Dr. R. Henshaw

180 Fullarton Road Dulwich SA 5065 TEL **1800 874 971** FAX **(08) 8333 8188** A.P.L 39625 **REQUEST FORM**

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 - NIPT

SINGLETON

*NEST All chromosomes ☐

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

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

* Please note: screening for "All other chromosomes" is not currently NATA accredited

ESSENTIAL INFORMATION Gestational Age

☐ LMP _____ **OR** EDD _____ **OR**

☐ BY SCAN Scan Date _____ wks _____ days

OTHER INFO ☐ IVF conceived ☐ Donor ☐ Age of Donor _____ yrs

TEST REQUESTED - FIRST TRIMESTER BIOMARKERS

SINGLETON

FIRST TRIMESTER BIOMARKERS ☐
(freeBhCG, PAPP_A, PLGF)

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 ☐

COMMENTS

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 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).

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

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

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