PRENATAL SCREENING REQUEST FORM - TWIN / SINGLETON

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. 39625 **REQUEST FORM**

RCPA/NATA ACCREDITATION NO. 2774

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

PATIENT DETAILS

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

PATIENT ADDRESS | TELEPHONE | REQUEST NO.

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

SELF DETERMINED ☐

TEST REQUESTED - NIPT

VIABILITY ULTRASOUND ☐

SINGLETON	TWINS
NEST Chromosomes 21, 18, 13 ☐	**NEST** Chromosomes 21, 18, 13 ☐
NEST Chromosomes 21, 18, 13 **plus Sex Chromosome Aneuploidies (SCA)** ☐	**PRESENCE OF Y CHROMOSOME** printed on report ☐
FETAL GENDER printed on report **(Note: the SCA option must be selected)** ☐	**Interpretation** **No Y** chromosome = 2 Female twins **Yes Y** chromosome = Either 1 or 2 male twins

ESSENTIAL INFORMATION

Gestational Age (requesting doctor to complete)

☐ LMP _____ **OR** ☐ EDD _____ **OR**

☐ BY SCAN Scan Date _____ ____ wks ____ days

Other essential information

IVF conceived ☐ Ovulation medication ☐

Donor egg ☐ Age of Donor ____ yrs

Have you had a previous Trisomy pregnancy? ☐ Yes ☐ No

If yes, which Trisomy? _____

COMMENTS

TEST REQUESTED - FIRST TRIMESTER BIOMARKERS

SINGLETON ☐ | TWINS ☐

FIRST TRIMESTER BIOMARKERS (freeBhCG, PAPP-A, PLGF) ☐

Note: Essential information must be completed for freeBhcg and PAPP-A results in MoMs

ESSENTIAL INFORMATION

Gestational Age

CRL _____ mm Scan date _____

Ethnicity (patient may complete)

☐ 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)

Other essential information (patient may complete)	Yes	No
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-eclampsia in her pregnancy with you?	☐	☐
Do you have High Blood Pressure?	☐	☐
Do you have Systemic-Lupus?	☐	☐
Do you have Antiphospholipid syndrome?	☐	☐

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 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)

NEST SA_V02

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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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

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

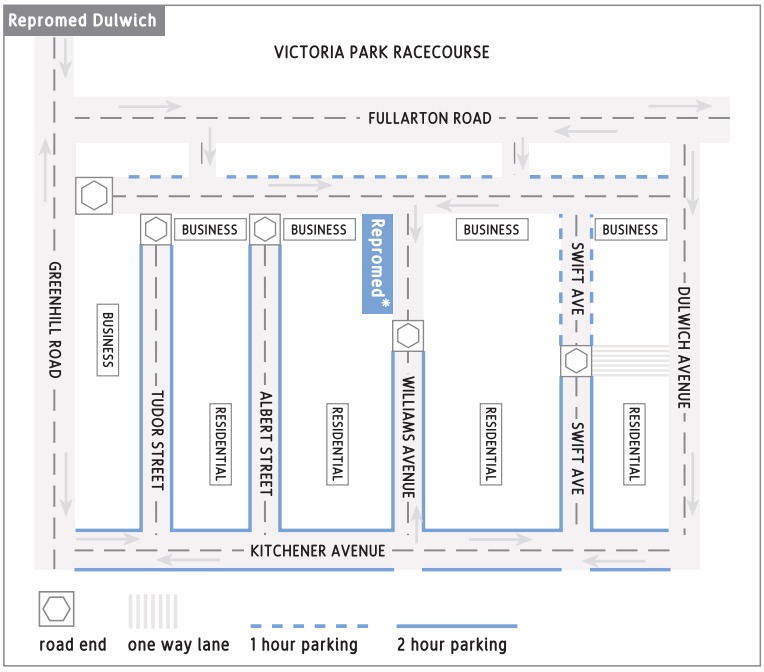
NOTE:

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.

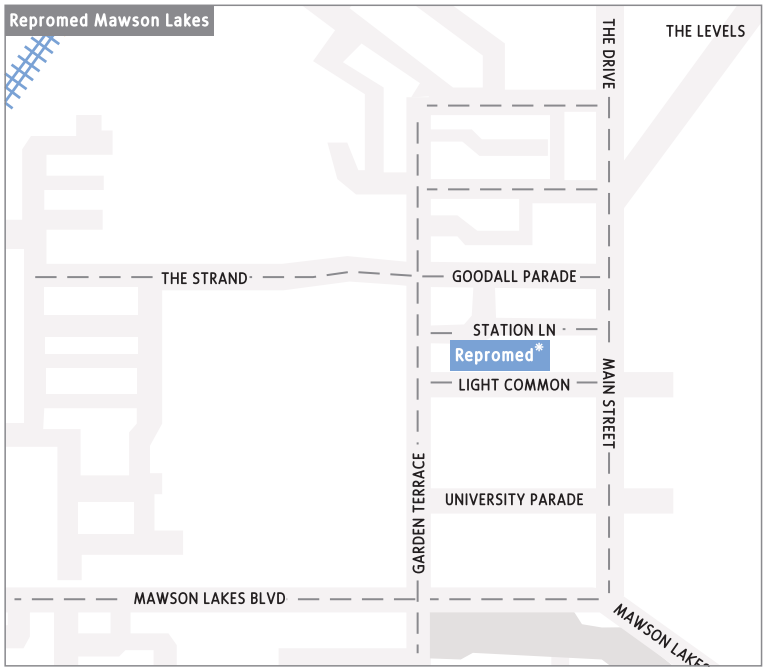
PATIENT ADVISORY STATEMENT:

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

Repromed Dulwich



Repromed Mawson Lakes



APPOINTMENT DETAILS

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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