

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 <input type="checkbox"/>			

TEST REQUESTED - NIPT

VIABILITY ULTRASOUND <input type="checkbox"/>	
SINGLETON	TWINS
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 printed on report <input type="checkbox"/>
FETAL GENDER printed on report (Note: the SCA option must be selected) <input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking aspirin in this pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a previous pregnancy with pre-eclampsia?	<input type="checkbox"/>	<input type="checkbox"/>
Did your mother have pre-eclampsia in her pregnancy with you?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have High Blood Pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Systemic-Lupus?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Antiphospholipid syndrome?	<input type="checkbox"/>	<input type="checkbox"/>

Hospital status of patient at specimen collection or date of service	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

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

