

# PRENATAL TESTING REQUEST FORM

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. 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 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 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 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

DATE / /

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/PHEBOTOMISTS

**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).

DATE / /

PATIENT'S SIGNATURE

DATE

PRACTITIONER'S USE ONLY (REASON PATIENT CANNOT SIGN)

# INFORMATION STATEMENT

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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

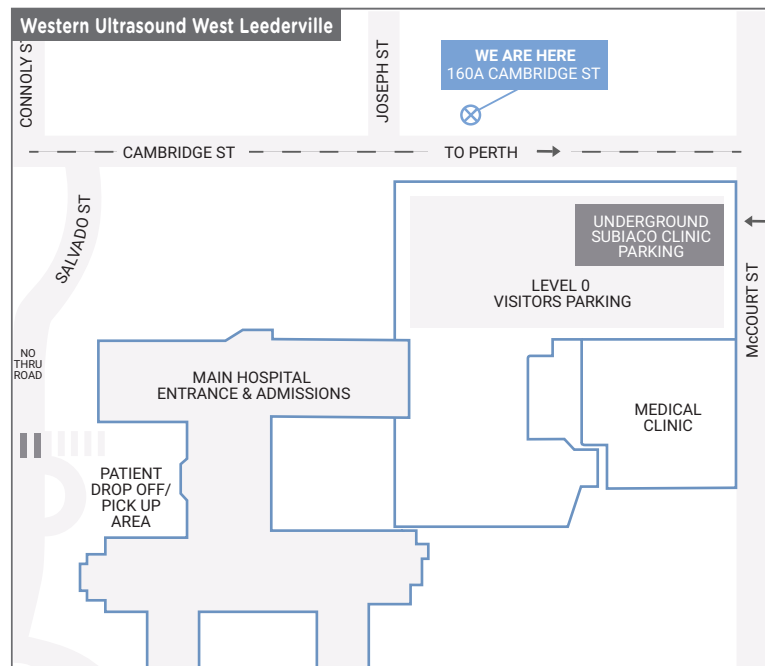
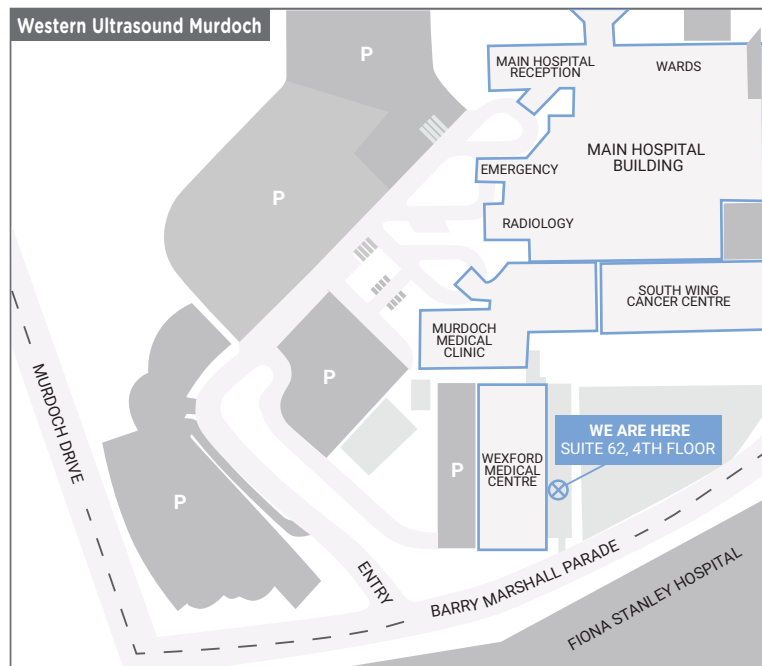
Western Ultrasound for Women WEST LEEDERVILLE.  
Tel. 9388 1340  
1/160a Cambridge St, West Leederville WA, 6007

### 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



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