# Eurofins Biomnis Pre-Natal Genetic Test Request, Information & Consent Form

## PATIENT DETAILS

Surname: _____

Forename: _____

Date of Birth: _____/_____/_____

Sex: Male ☐ Female ☐

Hospital/Clinic No.: _____

Laboratory No.: _____

Ward: _____

Physician: _____

## REQUESTING HOSPITAL/ CLINIC DETAILS

Hospital / Clinic Name:

_____

Department:

_____

Address: _____

_____

_____

Phone: _____Fax: _____

**PLEASE REMEMBER ALWAYS TO COMPLETE THE INFORMED CONSENT SECTION**

## SAMPLE DETAILS

Specimen Collection Date: _____/_____/_____/ Specimen Type (Amniotic Fluid): _____

Other Sample Type: _____

## TEST INFORMATION

### PRE-NATAL GENETICS

| TEST NAME | CODE | SELECT |
|---|---|---|
| QF PCR & Karyotyping (Amniotic Fluid) | ANEUP & KARPN | ☐ |
| Chromosome Analysis – Placenta/CVS | KARPL | ☐ |

**OTHER TESTS REQUIRED:**

_____

_____

_____

## INDICATIONS / SUSPECTED CONDITIONS / PREGNANCY INFORMATION

**PLEASE DESCRIBE INDICATIONS/ SUSPECTED CONDITION:** _____

_____

_____

**PREGNANCY INFORMATION:**

- LMP: _____/_____/_____ EDD: _____/_____/_____
  Day / Month / Year Day / Month / Year
- Scan Date: _____/_____/_____ i.e. Gestational Age _____/_____ of amenorrhea on scan day
  Day / Month / Year Weeks / Days

DOWN SYNDROME RISK EVALUATION RESULTS (IF AVAILABLE): _____

_____

FAMILY HISTORY OF CHROMOSOME ABNORMALITIES (DETAIL): _____

_____

_____

eurofins | Biomnis

# Eurofins Biomnis Pre-Natal Genetic Test Request, Information & Consent Form

## PATIENT HISTORY

**MEDICAL HISTORY**: _____

_____

_____

_____

**SURGICAL HISTORY**: _____

_____

_____

_____

**OBSTETRIC HISTORY**: _____

_____

_____

_____

## INFORMED CONSENT SECTION

- **Patient or Guardian:**

I/we the undersigned confirm that I/we have been fully informed by the Doctor/Pathologist/ Geneticist _____ regarding cytogenetic and/or molecular genetic tests that will be performed on cells and/or DNA extracted from my/our child's blood and/or tissue to:

- confirm or exclude the diagnosis of or a predisposition to a genetic disease.
- determine heterozygote status with a view to obtaining genetic counselling.
- examine gene locus/loci.

I/we give my/our consent to such testing and confirm that I/we have received all the necessary information according to the law.

**Patient/Guardian Signature:** _____ **Date:** _____/_____/_____

- **Doctor/ Pathologist/Genetic Consultant:**

The Cytogenetic and/or molecular genetic test information is to be given by the Clinical Pathologist prescribing the test, or by the Physician collecting the sample. All relevant issues regarding the involved pathology etiology, development, prognosis and potential treatment must have been raised by the Genetic consultant or the Physician and clearly understood by the patient. All information associated with the patient file will be retained by Eurofins Biomnis. The result must be reported to the Physician only.

**Doctor/Pathologist Signature:** _____ **Date:** _____/_____/_____