Prenatalsafe®
YOUR PATIENTS IN SAFE HANDS

REQUEST & CONSENT FORM

PLEASE WRITE CLEARLY USING CAPITALS LETTERS

REQUESTING CLINIC INFORMATION

REFERRING HEALTH CARE PROFESSIONAL NAME	CLINIC NAME	ACCOUNT NO.

CLINIC ADDRESS	POSTCODE

CLINIC TELEPHONE	CLINIC EMAIL

PATIENT INFORMATION

FIRST NAME	SURNAME	PATIENT ID / MEDICAL NO.

PATIENT ADDRESS	POSTCODE

PATIENT TELEPHONE	DATE OF BIRTH (DD/MM/YY)	MATERNAL WEIGHT (KG)	MATERNAL HEIGHT (CM)

PREGNANCY & SAMPLE INFORMATION

ULTRASOUND DATE (DD/MM/YY)	GESTATION (Weeks/Days)	BLOOD DRAW DATE (DD/MM/YY)	REDRAW?
			☐ YES ☐ NO

PREGNANCY? ☐ SINGLE ☐ TWIN

IVF? ☐ YES ☐ NO

IF IVF
NO. OF EMBRYOS:

VANISHING TWIN ☐ YES ☐ NO

IF TWIN
☐ MONOCHORIONIC ☐ DICHORIONIC

IF IVF:
☐ MALE HETEROLOGOUS ☐ HOMOLOGOUS
☐ FEMALE HETEROLOGOUS ☐ EMBRYO DONATION

INDICATION FOR TESTING & MEDICAL HISTORY

PREVIOUS NO. OF PREGNANCIES?		PREVIOUS NO. OF SPONTANEOUS ABORTIONS?	

FOETAL ABNORMALITIES IN PREVIOUS PREGNANCIES?	☐ YES ☐ NO	IF YES PLEASE GIVE DETAILS OF ABNORMALITIES IN PREVIOUS PREGNANCIES
ULTRASOUND ABNORMALITIES FOR CURRENT PREGNANCY?	☐ YES ☐ NO	IF YES PLEASE GIVE DETAILS OF ABNORMALITIES
HIGH SERUM SCREEN RESULT?	☐ YES ☐ NO	IF YES PLEASE GIVE DETAILS OF CURRENT ABNORMALITIES AND RESULTS OF ANY PREVIOUS TESTS (e.g. previous risk score for T21, T18, T13)
PATERNAL AGE? >40 YEARS	☐ YES ☐ NO	
MATERNAL AGE >35 YEARS	☐ YES ☐ NO	
PARTNER GENETIC DISEASE CARRIER?	☐ YES ☐ NO	IF YES PLEASE SPECIFY DISEASE, MUTATION IN GENE(S)
ANXIETY?	☐ YES ☐ NO	

EXPECTANT MOTHER AFFECTED BY
(TICK ALL THAT APPLY)

☐ AUTOIMMUNE / INFLAMATORY DISEASES ☐ TUMOUR / FIBROMAS

EXPECTANT MOTHER HAS UNDERGONE
(TICK ALL THAT APPLY)

☐ ALLOGENIC TRANSPLANTATION ☐ ALLOGENIC STEMCELL THERAPY
☐ RECENT TRANSFUSION ☐ RADIOTHERAPY
☐ IMMUNOTHERAPY ☐ HEPARIN THERAPY

OTHER ONGOING PHARMACOLOGICAL THERAPIES OF GENETIC DISEASES

PLEASE TURN OVER

eurofins

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TEST TYPE REQUIRED (Tick one only)			
☐	PrenatalSafe® 3	Chromosomes 21, 18, 13 only	UK
☐	PrenatalSafe® 5	Chromosomes 21, 18, 13, X, Y	
☐	PrenatalSafe® 5 Plus DiGeorge	Chromosomes 21, 18, 13, X, Y + DiGeorge syndrome	ITALY*
☐	PrenatalSafe® Plus	Chromosomes 21, 18, 13, X, Y panel 6 Microdeletions + Trisomies 9 + 16 option	
☐	PrenatalSafe® Karyo	Genome-wide NIPT that provides karyotype-level insight	
☐	PrenatalSafe® Karyo Plus	Genome-wide NIPT that provides karyotype-level insight + panel 9 Microdeletions	
☐	PrenatalSafe® COMPLETE	PrenatalSafe® Karyo + Certain Inherited & De Novo Disorders	
☐	PrenatalSafe® COMPLETE Plus	PrenatalSafe® Karyo Plus + Certain Inherited & De Novo Disorders	
☐	PrenatalSafe® Full Risk	PrenatalSafe® Karyo + Certain Inherited & De Novo Disorders + Carrier Screening	

See corresponding patient information leaflet for more test information * Referred to a specialised genomics lab, (*Eurofins Genoma, Via di Castel Giubileo, 62, 00138 Roma RM, Italy*) PrenatalSafe Karyo is accredited to ISO: 15189

DO YOU WISH TO KNOW THE FOETAL SEX?	☐ YES ☐ NO (**)

Sex determination is reported as presence/absence of Y chromosome for twin pregnancies. ** If a sex chromosome aneuploidy is tested & detected, the foetal sex will be disclosed when the anomaly is reported. If no sex chromosome aneuploidy is detected, foetal sex will not be reported unless requested.

PATIENT CONSENT

- I consent to the test I have chosen, understand where my test will be processed and confirm that I have been informed about the purpose, scope and limitations of the test by my healthcare provider.
- I understand this is a screening test for selected abnormalities and that results do not exclude the possibility of other abnormalities that have not specifically been screened for.
- I understand that the results should be reviewed by my healthcare provider.
- I have had the opportunity to ask questions, I have received the patient information leaflet and understand I can request further information and genetic counselling.
- I agree that my personal data may be used for auditing and quality control purposes and understand I can withdraw my consent at any point.

Signature **Date: DD / MM / YYYY**

X _____

HEALTHCARE PROFESSIONAL CONSENT

- I confirm I am a registered Healthcare professional
- I verify that the patient and prescriber information in this form is complete and accurate to the best of my knowledge
- I verify that I have requested this screening test based on my professional judgement of medical necessity.
- I have addressed the limitations of this test and have answered any questions to the best of my ability.
- I understand that Eurofins may need additional information, from the healthcare provider and I agree to provide it as needed for purposes of reimbursement.
- I have given the patient information leaflet
- I have taken and packed the sample in accordance with the kit instructions

Signature **Date: DD / MM / YYYY**

X _____

After the test has been performed there is usually a small amount of sample left. You can indicate below that you are also giving your permission for this sample and the associated data to be kept to aid with the development and improvement of non-invasive testing. You are under no obligation to consent to your sample being used for this purpose and declining will not affect your standard of care. If you are happy for your excess sample to be used for test development, please sign below. Your information and pregnancy will be anonymised, meaning that your identity will be protected.

- I consent to the use of leftover specimen and for anonymised health information to be stored and used for the development or enhancement of future non-invasive testing.

Signature **Date: DD / MM / YYYY**

X _____

To withdraw any of the consents above, please email: **GeneticEnquiresUK@biomnis.co.uk**

CONTACT INFORMATION
Eurofins Biomnis, 8 Huxley Road, Surrey Research Park, Guildford, GU2 7RE ,Tel: 07501805142

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