

# TEST REQUEST FORM: PRENATALSEQ (NON-INVASIVE PRENATAL SCREENING)



\*Mandatory fields

## PATIENT DETAILS

Forename\* \_\_\_\_\_  
Surname\* \_\_\_\_\_  
Hospital ID \_\_\_\_\_  
DOB (DD/MM/YYYY)\* \_\_\_\_\_

## CLINICAL INFORMATION

Gestational age at the date of sample draw\*<sup>1</sup>

Weeks: \_\_\_\_\_ Days: \_\_\_\_\_

Maternal BMI\* \_\_\_\_\_

Number of Fetuses\*<sup>2</sup>

1  2

IVF Pregnancy

Yes (Egg donor is:  Self  Non-self)

No

<sup>1</sup>Patient must be at least 10 weeks 0 days in gestational age (as determined by a scan).

<sup>2</sup>This test is not available for pregnancies with more than two fetuses.

## TEST REQUEST DETAILS

Trisomy 13, 18, and 21

Please mark additional test options

Fetal Sex Determination\*<sup>3</sup>

Yes  No

Sex Chromosome Aneuploidies\*<sup>4</sup>

Yes  No

<sup>3</sup> Fetal sex considers the presence or absence of a Y chromosome, and it will be reported as "male" or "female" for singleton pregnancies. For twin pregnancies, presence of a Y chromosome indicates at least one male fetus, and absence of a Y chromosome indicates both fetuses are female.

<sup>4</sup> Analysis of sex chromosome aneuploidies (X, XXX, XXY, XYY) is an option available only for singleton pregnancies. If analysis of sex chromosomes aneuploidies is performed, and an aneuploidy is detected, the sex of the fetus will also be determined, even if it was not requested. If the "No" option is selected, any detected sex chromosome aneuploidies **will not** be reported.

It should be noted that the accuracy of screening results can be adversely affected by certain maternal and fetal factors, including but not limited to: recent maternal blood transfusion; maternal prior bone marrow / organ transplant / stem cell transplant; radiation/ immune/ stem cell therapy; maternal autoimmune disease or cancer unless in remission; maternal neoplasms (benign and malignant); maternal mosaicism; maternal copy number variations, balanced translocations or whole chromosomal abnormalities; fetoplacental mosaicism / confined placental mosaicism and fetal demise / vanishing twin.

## HEALTH PRACTITIONER DETAILS

Account ID \_\_\_\_\_  
Full Name\* \_\_\_\_\_  
Phone \_\_\_\_\_  
Email \_\_\_\_\_  
Institution\* \_\_\_\_\_  
Address 1 \_\_\_\_\_  
Address 2 \_\_\_\_\_  
City/town \_\_\_\_\_  
Post Code \_\_\_\_\_  
Country \_\_\_\_\_

## SAMPLE DETAILS

Sample Type

7-10ml maternal peripheral whole blood collected in a STRECK Cell-Free DNA Blood Collection Tube

Date Collected (DD/MM/YYYY)\* \_\_\_\_\_

Time Collected (hh:mm) \_\_\_\_\_

Is this a repeat sample?  Yes  No

## CONSENT

\*Please, indicate how long you would like Genseq to store DNA sequencing raw data on your behalf:

12 months (default retention time where no option is chosen)

18 months

In addition, in order to fulfil your instructions to perform the requested genetic testing as undertaken in the context of an accredited genetic testing service, you understand that other data types, such as patient data received on this Test Request Form, laboratory QC data and report data will be stored for a further period of years taking account of applicable law, regulation and industry guidance. In returning this Test Request Form for processing you are instructing us in writing to undertake such processing on your behalf.

\*I hereby confirm that I have obtained written informed consent from the patient for this test to be performed, including consent for health practitioners registered under my account to access the report.

## BILLING AND REPORT DETAILS

The invoice for this test will be sent to the default billing address associated with your Account ID. If your institution requires a PO number, please insert it here.

PO Number \_\_\_\_\_

The report for this test will be made available in your account on Genseq's online ordering portal. If you need other health practitioners to have access to the report, please ensure they are registered under your account to ensure appropriate communication.

## INTERNAL USE ONLY

Sample ID \_\_\_\_\_