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

***Mandatory fields**

PATIENT DETAILS

Forename* _____

Surname* _____

Hospital ID _____

DOB (DD/MM/YYY) * _____

CLINICAL INFORMATION

Gestational age at the date of sample draw*[1]

Weeks: ____ Days: ____

Maternal BMI* _____

Number of Foetuses*[2]

☐1
☐2 (☐ monozygotic ☐ dizygotic ☐ unknown)

IVF Pregnancy

☐Yes (Egg donor is: ☐ Self ☐ Non-self)
☐No

[1]Patient must be at least 10 weeks 0 days in gestational age (as determined by a scan).
[2]This test is not available for pregnancies with more than two foetuses.

TEST DETAILS

☐ Trisomy 13, 18, and 21

Please mark any additional test options requested

☐ Foetal Sex[3]
☐ Sex Chromosome Aneuploidies[4]

[3] Foetal sex considers the presence or absence of a Y chromosome, and it will be reported as "male" or "female". For twin pregnancies, "male" means that a Y chromosome was detected in at least one of the foetuses, and "female" means that a Y chromosome was not detected in either foetus.

[4] Analysis of sex chromosome aneuploidies is an option available for singleton pregnancies. If analysis of sex chromosomes aneuploidies is performed, and an aneuploidy is detected, the sex of the foetus will also be determined, even if it was not requested Please refer to our Laboratory User Guide for information on the sample requirements for this test, and to confirm eligibility for your patient. This test screens for Trisomy 13, 18, and 21, and optionally sex chromosome aneuploidies (X, XXX, XXY, XYY) and foetal sex. Aneuploidies involving other chromosomes, polyploidies (such as triploidy), and partial deletions or duplications are not evaluated. If an abnormality is detected, the mosaicism level will not be reported.

This test is not clinically indicated for patients that have multiple gestation pregnancies with three or more foetus. In addition, the accuracy of screening results can be adversely affected by certain maternal and foetal 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; foetoplacental mosaicism / confined placental mosaicism and foetal demise / vanishing twin.

HEALTH PRACTITIONER DETAILS

Account ID* _____

Full Name* _____

Phone* _____

Email* _____

Institution* _____

Address 1* _____

Address 2 _____

City/town* _____

County/ State* _____

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/YYY)* _____

Time Collected (hh:mm) _____

Is this a repeat sample? ☐Yes ☐No

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.

☐ ***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.**

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

☐ 6 months ☐ 12 months

In addition, in order to (a) fulfil your instructions to the requested perform genetic testing, and (b) for us to provide further cascade genetic tests for you, each 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.

INTERNAL USE ONLY

Sample ID _____