Yhtyneet Medix laboratoriot

NIPT test request form

Client name and number_____

Sample id of the sender_____ Contact person_____

Fax/tel number, for the report_____

NAME OF THE PATIENT_____**ID**_____

Test alternatives:

☐ **B -NIPTtri** KL 6373 (chromosomes 13, 18, 21 + X and Y)

☐ **B -NIPTdel** KL 6374 (chromosomes 13, 18, 21 + X and Y and six microdeletion syndromes (CATCH/ Di George, 1p36, Cri du Chat, Angelman, Prader-Willi ja Wolf-Hirshhorn)

☐ **Twin pregnancy, test for only chromosomes 13, 18 ja 21 + Y** (B –NIPTtri KL 6373)

Indication:

☐ Advanced maternal age ☐ Positive serum screen, risk value_____

☐ Abnormal ultrasound ☐ Increased risk for chromosome aneuploidy, which?_____

☐ worry ☐ Other_____

Clinical information:

Gestational age_____ ☐ Based on ultrasound / ☐ Other, what? _____

Date of sample draw_____(ddmmvvvv)

Maternal height: _____ Maternal weight : _____

Amount of fetus: _____ (notice that in twin pregnancies only B –NIPTtri test is possible)

Sex of the fetus should be mentioned ☐ Yes ☐ No

_____

By signing this form I consent that I have been informed of the meaning , benefits, risks and limitations of NIPT test (Patient information). I have also been offered to have a possibility to ask more about NIPT test.

Date_____ Signature of the patient_____