SYNLAB neoBona®

NEOBONA
BAR CODE

Test Requisition Form

(4505) WIJ -LCB – SYNLAB Suomi Oy

PERSON INFORMATION	ORDERING PHYSICIAN INFORMATION
First name: * Required fields*	**Name:** *
Last name: *	**Telephone number:** *
ID: *	**Centre name:** *
	E-mail: *

neoBona® select with ✔ the appropriate option

Singleton or twin pregnancy	Singleton pregnancies only
☐ neoBona (B -NIPT ATK 10795) • Trisomies 21, 18, 13 ☐ Fetal sex (presence of Y chromosome) * * Determines fetal sex in singleton pregnancies. In twins, if Chr. Y is detected, it can be established that at least one of the two fetuses is a male, if not it is inferred that both fetuses are female.	☐ neoBona (B -NIPTtri / B -NIPTadv KL 6373) • Trisomies 21, 18, 13 • Aneuploidies X, Y • Fetal sex

CLINICAL INFORMATION

Person's date of birth: * / / (day/month/year) | **Weight:**____kg **Height:**____cm | **Redraw:** * ☐ No ☐ Yes

Gestational age: *____weeks____days
On date: * / / (day/month/year)

Measured by: * ☐ LMP ☐ Ultrasound (CRL) ☐ Date of transfer (IVF)

Number of fetuses: * ☐ 1 ☐ 2 ☐ Vanishing twin

IVF pregnancy: * ☐ No ☐ Yes

If IVF, eggs: * ☐ Self ☐ Non-self
No. of embryos transferred:___ No. of gestational sacs:___

Age at eggs retrieval: *____years

Clinical indications: * ☐ Advanced maternal age ☐ Abnormal ultrasound ☐ Increased risk first trimester screening (1/____) ☐ Clinical history ☐ Maternal request ☐ Other: _____

ORDERING PHYSICIAN SIGNATURE

Based on the indications listed above, I hereby commission the **neoBona®** test (any of the test options) and confirm that to the best of my knowledge, the patient data and the data concerning the referring physician contained on this form are accurate. I confirm that I have advised the patient concerning the **neoBona®** test as required under law, and that I have received the patient's explicit consent to perform the **neoBona®** test.

Physician signature: * _____ **Date:** * / / (day/month/year)

PATIENT INFORMED CONSENT

By signing this form, I confirm that I have read, understood, and accepted the information on the patient information form. I have received genetic counseling from my doctor (or a person assigned by my doctor) regarding the purpose of this screening and its potential risks and limitations. I have received sufficient information about the genetic changes investigated by the test and the scope of the test. I have been given the opportunity to ask all my questions and I got an answer to every question. I had enough time to think about the information and my choice to complete the screening test. I consent to this screening being carried out and I will discuss the result and appropriate medical treatment with a healthcare professional. I have been informed and accept that neoBona is a screening test and that an "abnormal" result does not necessarily mean that the fetus has a chromosomal abnormality. Likewise, I understand that a "normal" result does not completely rule out the possibility of a chromosomal abnormality. B -NIPT: I have been informed and agree that this screening will reveal the sex of the fetus if the option "Want to determine sex" is selected. I understand and accept that only the clinical test ordered on this form will be performed on my blood sample. I accept the above and authorize SYNLAB to perform the neoBona screening test.

The test is produced by SYNLAB. The analysis of the test is carried out in the laboratory of SYNLAB DIAGNOSTICOS GLOBALES SA in Spain. Data processing takes place in the EU. The results of the screening are transferred to SYNLAB Suomi Oy and to the doctors and/or treating unit mentioned in this form. After the sample has been taken, your research data and results will be processed and stored in accordance with the general regulations of the EU and the national regulations of Finnish social and health care. For your information, the registrar is the unit ordering the test. If you want to use the rights of the registered person, please contact the health care unit treating you.

Person's signature: * _____ **Date:** * / / (day/month/year)

DRAW CENTER DETAILS

Blood draw center:	**Draw date:** * / / (day/month/year)
Centre code:	

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