

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)
- B -NIPTsup** ATK 10325 (chromosomes 13, 18, 21)
- 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 –NIPT-D 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 _____