PATIENT DETAILS

GENOMA® Molecular Genetics Laboratories Group

PrenatalSafe®

Protocol no. (internal use only): _____

Name_____

Surname_____

Date of birth_____ Place of birth_____

VAT no. _____

Address:_____

Phone no.: _____

Date of blood withdraw _____

Gynecologist name:_____

Address:_____

Phone no.: _____

E-mail: _____

ORDERING LABORATORY / CLINICIAN

vita LABORATORIOT

asiakasneuvonta@vita.fi
sanna.taskinen@vita.fi

PATIENT MEDICAL HISTORY

_____

_____

PREGNANCY HISTORY

Patient current weight Kg _____ Patient height_____

Gestational age at draw _____ + days _____

Gestational age calculated by:

☐ Ultrasound; ☐ last menstrual period; ☐ IVF treatment

Twin pregnancy? ☐ Yes; ☐ NO Monochorial ☐ Bichorial ☐

IVF Pregnancy? ☐ Yes; ☐ NO

☐ Homologous pregnancy; ☐ Heterologous Pregnancy

☐ Embryo donation; ☐ Eggs donation; ☐ Sperm donation

INDICATION FOR TESTING

☐ Advanced maternal age; ☐ Advanced paternal age;

☐ Parental anxiety (low-risk)

☐ Abnormal ultrasound (describe): _____

☐ Previous pregnancy with aneuploidy;

☐ Abnormal maternal serum screening test;

☐ Partner carrier of a genetic disorder: ☐ Male ☐ Female

☐ Specify disorder: _____

☐ Specify gene and mutation: _____

☐ Other indication _____ ☐ None

TYPE OF TEST

☑ PrenatalSAFE® Plus test (for chr. 21, 18, 13, X, Y) * (can not be requested for bichorial pregnancy) + ☑ Panel 6 Microdeletion*

*This option includes the following syndromes:

22q11 deletion (DiGeorge); 15q11 deletion (Angelman/ Prader-Willi); 1p36 deletion, 4p- (Wolf-Hirschhorn); 5p- (Cri-du-chat)

Do you wish to know the fetal gender? ☐ Yes; ☐ NO

Is it a redraw? ☐ Yes; ☐ NO

BILLING

☑ Sending facility

vita LABORATORIOT

REPORTING PREFERENCES

☑ PHYSICIAN / LABORATORY

vita LABORATORIOT

Signature _____

PATIENT CONSENT STATEMENT:

By signing this form, I, the patient having the testing performed, acknowledge that:

(i) I have received and read or have had read to me the above informed consent information about the PrenatalSafe® Non-Invasive Prenatal Test (NIPT) in its entirety and realize I may retain a copy for my records;.

(ii) I have had the opportunity to ask questions of my health care provider regarding this test, including the reliability of test results, the risks, and the alternatives prior to my informed consent.;

(iii) I have discussed with the healthcare provider ordering this test the reliability of positive or negative test results and the level of certainty that a positive test result for a given disease or condition serves as a predictor of that disease or condition;

(iv) I have been informed about the availability and importance of genetic counseling and have been provided with information identifying an appropriate healthcare provider from whom I might obtain such counseling;

(v) I consent to the use of the leftover specimen and health information as described in the Patient Informed Consent;

(vi) I consent to having this test performed and I will discuss the results and appropriate medical management with my healthcare provider.

Date: _____

_____
Signature of Patient

_____
Printed Name

The physician who has collected the consent (first and last name) _____

Tel. _____ E-Mail _____

Signature and stamp of the physician who has collected the consent:_____