Ninalia
by eurofins biomnis

Test Request form
Detection of chromosomal abnormalities
by analysis of circulating cell-free DNA

PRESCRIBING CLINICIAN

First name(s): ..... Surname: .....
Address: .....
Post code: ⌊ ⌋ City: .....
Country: .....
Tel.: ⌊ ⌋ Fax: ⌊ ⌋
Email: .....
Date: ⌊D D⌋⌊M M⌋⌊Y Y Y Y⌋

Clinician's stamp

Protocol no. (internal use only)

Signature :

PATIENT

First name(s): .....
Surname: .....
Name of birth: .....
Adresse : .....
Post code: ⌊ ⌋ City: .....
Country: .....

Date of birth: ⌊D D⌋⌊M M⌋⌊Y Y Y Y⌋

REQUIRED INFORMATION

Gestational age at draw: Weeks: ..... Days: .....
Gestational age calculated by Ultrasound: .....Date: ⌊D D⌋⌊M M⌋⌊Y Y Y Y⌋
Vanishing twins: ☐ YES ☐ NO

Number of live fetuses:..... Please precise if ultrasound abnormalities: .....

INDICATION FOR TESTING

☐ Primary screening
☐ Twin pregnancy
☐ History of pregnancy with trisomy 21, 18 or 13
☐ 2nd draw
☐ Couple where one of the members carries a Robertsonian translocation involving chromosomes 13 or 21
☐ Maternal Serum Markers screening: ☐ 1st term ☐ 2nd term Risk 1/ .....
☐ Other: .....
☐ Parental wish

TEST REQUESTED *(please tick all that apply)*

☐ Trisomies 21, 18 and 13

Optional:
☐ Fetal gender determination: ☐ YES ☐ NO

PATIENT CONSENT

I consent to the test(s) I have chosen and confirm that I have been informed about the purpose, scope, and limitations of the test by my healthcare provider. I understand this is a screening test for selected abnormalities and the results should be reviewed by my healthcare provider. I have had the opportunity to ask questions and understand that I can request further information and genetic counselling.

I consent to the use of the leftover specimen and health information in the Patient Informed Consent document.

I agree that my personal data may be used for auditing and quality control purposes as outlined in the Patient Informed Consent document and understand I can withdraw my consent at any point.

Date: ⌊D D⌋⌊M M⌋⌊Y Y Y Y⌋

Patient's signature

PRESCRIBINGCLINICIANCONSENT

I verify that the patient and prescriber information in this form is complete and accurate to the best of my knowledge and that I have requested this screening test based on my professional judgement of medical necessity.

I have addressed the limitations of this test, and have answered any questions to the best of my ability.

I understand that Eurofins may need additional information, and I agree to provide it as needed.

Date: ⌊D D⌋⌊M M⌋⌊Y Y Y Y⌋

Prescribing clinician's signature

LABORATORY

Blood sample taken on: ⌊D D⌋⌊M M⌋⌊Y Y⌋ **at** ⌊ ⌋ **hr** ⌊ ⌋ **min**

839-INTGB - November 2020