

# Biomnis Pre-Natal Genetic Test Request, Information & Consent Form



## PATIENT DETAILS

Surname: \_\_\_\_\_  
Forename: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Sex: Male:  Female:   
Hospital/Clinic No.: \_\_\_\_\_  
Laboratory No.: \_\_\_\_\_  
Ward: \_\_\_\_\_  
Physician: \_\_\_\_\_

## REQUESTING HOSPITAL / CLINIC DETAILS

Hospital/Clinic Name: \_\_\_\_\_  
Department: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PLEASE REMEMBER ALWAYS TO COMPLETE THE INFORMED CONSENT SECTION**

## SAMPLE DETAILS

Specimen Collection Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sample Type (Amniotic Fluid): \_\_\_\_\_  
Other Sample Type: \_\_\_\_\_

## TEST INFORMATION

### PRE-NATAL GENETICS

TEST NAME	CODE	SELECT
QF PCR & Karyotyping (Amniotic Fluid)	ANEUP & KARPN	<input type="checkbox"/>
Chromosome Analysis – Placenta/CVS	KARPL	<input type="checkbox"/>

### OTHER TESTS REQUIRED:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## INDICATIONS / SUSPECTED CONDITIONS / PREGNANCY INFORMATION

PLEASE DESCRIBE INDICATIONS / SUSPECTED CONDITION: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PREGNANCY INFORMATION:

- LMP: ..... / ..... / .....  
Day / Month/ Year
- EDD: ..... / ..... / .....  
Day / Month/ Year
- Scan Date: ..... / ..... / ..... i.e. Gestational Age ..... / ..... of amenorrhea on scan day  
Day / Month/ Year Weeks / Days

DOWN SYNDROME RISK EVALUATION RESULTS (IF AVAILABLE): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FAMILY HISTORY OF CHROMOSOME ABNORMALITIES (DETAIL): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## PATIENT HISTORY

**MEDICAL HISTORY:** \_\_\_\_\_

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**SURGICAL HISTORY:** \_\_\_\_\_

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**OBSTETRIC HISTORY:** \_\_\_\_\_

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## INFORMED CONSENT SECTION

### • Patient or Guardian:

I/we the undersigned confirm that I/we have been fully informed by the Doctor/Pathologist/ Geneticist \_\_\_\_\_ regarding cytogenetic and/or molecular genetic tests that will be performed on cells and/or DNA extracted from my/our child's blood and/or tissue to:

- confirm or exclude the diagnosis of or a predisposition to a genetic disease.
- determine heterozygote status with a view to obtaining genetic counselling.
- examine gene locus/loci.

I/we give my/our consent to such testing and confirm that I/we have received all the necessary information according to the law.

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### • Doctor/ Pathologist/Genetic Consultant

The Cytogenetic and/or molecular genetic test information is to be given by the Clinical Pathologist prescribing the test, or by the Physician collecting the sample. All relevant issues regarding the involved pathology etiology, development, prognosis and potential treatment must have been raised by the Genetic consultant or the Physician and clearly understood by the patient. All information associated with the patient file will be retained by Biomnis Ireland. The result must be reported to the Physician only.

Doctor/Pathologist Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_