eurofins

REQUEST & CONSENT FORM

PLEASE WRITE CLEARLY USING CAPITAL LETTERS

*Mandatory fields

Place the form **barcode** here

REQUESTING CLINIC INFORMATION

REFERRING HEALTH CARE PROFESSIONAL NAME*	CLINIC NAME*	CLINIC TELEPHONE
CLINIC EMAIL*	**CLINIC ADDRESS**	**CLINIC POSTCODE**

PATIENT & SAMPLE INFORMATION

FIRST NAME*	SURNAME*	DATE OF BIRTH* (DD/MM/YYYY)
MEDICAL RECORD NO.		**REPEAT SAMPLE** ☐

ULTRASOUND DATE* (DD/MM/YYYY)	BLOOD DRAW DATE* (DD/MM/YYYY)	GESTATION AT DRAW* (WEEKS + DAYS)

PREGNANCY TYPE* ☐ Single ☐ Dichorionic Twin ☐ Monochorionic Twin ☐ Vanishing Twin (IF APPLICABLE)

INDICATION FOR TESTING/RISK FACTORS* (TICK ALL THAT APPLY)

☐	Fetal abnormalities in previous pregnancies (please give details)	☐	Paternal age > 40 years
☐	High serum screen result (please give details)	☐	Patient choice
☐	Biological father genetic disease carrier (please give details)	☐	Maternal age > 35 years
☐	Ultrasound abnormalities for current pregnancy (please give details)		

HAS EXPECTANT MOTHER UNDERGONE ANY OF THE FOLLOWING?

Maternal genetic condition related to chromosome 13, 18, 21 or the sex chromosomes, immunotherapy unrelated to IVF, organ transplant or stem cell therapy, recent blood transfusion (< 4 months previous) and/or currently undergoing treatment for cancer. **YES** ☐

PLEASE FILL IN ANY OTHER RELEVANT MEDICAL DETAILS IN BOX BELOW

e.g., risk score for T21, T18, T13 if known

TEST TYPE REQUIRED* (TICK ONE ONLY)

☐	**Prenatalsafe® 3**	Chromosomes 21, 18, 13 only
☐	**Prenatalsafe® 5**[1]	Chromosomes 21, 18, 13, X, Y

DO YOU WISH TO KNOW THE FETAL SEX?*[2] YES ☐ NO ☐

FOOTNOTES

[1]Sex chromosome aneuploidies are not reported for twin pregnancies (including single with vanishing twin). A Prenatalsafe 3 report will be issued instead.

[2]Sex determination is reported as presence/absence of Y chromosome for single pregnancies with vanishing twin or twin pregnancies. Fetal sex will not be reported unless explicitly requested. When sex chromosome aneuploidies are tested and detected with Prenatalsafe 5, fetal sex will be disclosed if an anomaly is reported. If no sex chromosome aneuploidy is detected, fetal sex will not be reported unless requested.

PLEASE TURN OVER

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*Mandatory fields

PATIENT CONSENT*

- I consent to the test I have chosen, understand where my test will be processed 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 that results do not exclude the possibility of other abnormalities that have not specifically been screened for.
- I understand that the results should be reviewed by my healthcare provider.
- I have had the opportunity to ask questions, I have received the patient information leaflet and understand I can request further information and genetic counselling.
- I agree that my personal data may be used for auditing and quality control purposes and understand I can withdraw my consent at any point.
- Data will not be transmitted abroad, and if in constancy of contractual relationship your data are processed in a non-EU state, the rights attributed to you by EU regulations will be guaranteed and you will be promptly notified (IE).

FULL NAME (USE CAPITAL LETTERS)

*

SIGNATURE **DATE:** DD/MM/YYYY

* *

HEALTHCARE PROFESSIONAL CONSENT*

- I confirm I am a registered Healthcare professional.
- I verify that the patient and prescriber information in this form is complete and accurate to the best of my knowledge.
- I verify 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 from the healthcare provider and I agree to provide it as needed for purposes of reimbursement.
- I have given the patient the information leaflet.
- I have taken and packed the sample in accordance with the kit instructions.

FULL NAME (USE CAPITAL LETTERS)

*

SIGNATURE **DATE:** DD/MM/YYYY

* *

PATIENT:

I consent to the use of leftover specimen and for my anonymised health information to be stored and used for the development or improvement of future non-invasive testing.

YES ☐ NO ☐

BILLING (IF APPLICABLE)

☐	**Patient**	Payment Confirmation No. (Online receipt number or similar)
☐	**Clinic**	

ADDITIONAL INFORMATION

PATIENT ADDRESS	PATIENT POSTCODE	PATIENT TELEPHONE

MATERNAL WEIGHT		MATERNAL HEIGHT	

IVF INFORMATION (IF APPLICABLE) ☐ Homologous ☐ Embryo Donation ☐ Sperm Donation ☐ Egg Donation

To withdraw any of the consents above,
please email: **ClientServices@ctie.eurofinseu.com**

Or call: **1800 252 966**

Unit 3, Sandyford Business Centre/Business Park,
Blackthorn Rd, Dublin18, D18 E528,

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