DX-PD-S151 V1.0

REQUEST FORM

NIFTY™ BGI technology inside

Sample Barcode

☐ NIFTY-Focus (T21, T18, T13, SCA and Gender)

☐ NIFTY-Pro (T21, T18, T13, SCA, Gender and other Additional findings)

☐ NIFTY-Twin (T21, T18, T13, Y Chromosome)

Non-invasive Prenatal Genetic Testing for Fetal Chromosomal Aneuploidies

PATIENT INFORMATION

*First Name(Given Name) **IN CAPITAL**

*Last Name(Surname) **IN CAPITAL**

*ID/Passport No.

Nationality

*DATE OF BIRTH D D-M M-Y Y Y Y

Phone

Weight(kg) Height(cm)

HOSPITAL/CLINIC INFORMATION

*HOSPITAL/CLINIC

Doctor Name

Tel/Email

HISTORY

Gravida(n) Parity(n)

Date of Last Delivery/Abortion D D-M M-Y Y Y Y

Spontaneous Abortions

Terminations of Pregnancies

Molar pregnancies

Ectopic pregnancies

☐my 1st pregnancy ☐not my 1st pregnancy ☐history of tumor ☐abnormal reproductive history ☐abnormal ultrasound result

I have received ☐transplant surgery ☐stem cell therapy ☐allogenic blood transfusion ☐cellular immunotherapy ☐heparin therapy ☐human serum albumin therapy ☐immunotherapy on(dd/mm/yyyy): _____

☐my BMI>40 ☐took medication during pregnancy, the name of the drug is:_____

I have abnormal karyotype with ☐qh+/, ps+/, pstk+/, pss ☐with dup, del, t, rob, inv, p-, q-, p+, q+, +mar

(additional consent may be needed if boxes above are checked)

CURRENT PREGNANCY

LMP

D D-M M-Y Y Y Y

***Working EDC (by LMP/USG)**

D D-M M-Y Y Y Y

***Gestational Week (w+d)**

IVF

☐YES

☐NO

***USG**

Date: D D-M M-Y Y Y Y

☐Singleton

☐Twin pregnancy

☐DCDA ☐MCDA ☐MCMA

☐ Vanishing Twin

☐Occurred before 8 GW

☐Blood sampling after 8 weeks from vanishing occurence

Structure

☐Normal

☐Abnormal

Please specify_____

Prior Down Syndrome Screening Test

☐No,first time for down syndrome screening

☐Yes, the estimated risk of T21: 1/____, T18: 1/___, T13:_____

Type of test:

☐1st Trimester NT+Bch

☐1st Trimester NT only

☐1st Trimester Bch only

☐2nd Bch only

☐1st and 2nd Trimester integrated

☐2nd Trimester USG only

☐Other, please specify_____

SAMPLE INFORMATION

Sample type
☐Whole blood
☐Plasma

Sampling tube
☐Streck tube
☐Geneseek Tube
☐Others

Shipment condition
☐Room Temp
☐Dry Ice
☐Blue Ice

***Blood collection**
Date: D D-M M-Y Y Y Y
Time

***GENDER REQUESTED (Singleton only)**

Include the Fetal gender on the report

☐YES ☐NO

(If box is not choosen, gender will be reported.)

PHYSICIAN STATEMENT

We/I confirm that the patient has been duly informed about the specific purpose of this genetic screening test, its risks, and its limitations.
We/I confirm that the patient has been informed that the test will cover the disorder(s) indicated on this form, and we/I will ensure that the test results will be interpreted to the patient in an appropriate manner, and that the patient will not receive the results without accompanying genetic counseling.
We/I have answered all the patient's questions with regard to this test.

Physician Name:

***Signature:**