Prenatalsafe®
YOUR PATIENTS IN SAFE HANDS

REQUEST & CONSENT FORM

PLEASE WRITE CLEARLY USING CAPITAL LETTERS

*Mandatory fields

If applicable: Place the form **barcode** here

REQUESTING CLINIC INFORMATION

REFERRING HEALTHCARE PROFESSIONAL NAME*	CLINIC NAME*	CLINIC TELEPHONE
CLINIC EMAIL*	**CLINIC ADDRESS**	**CLINIC POSTCODE**

PATIENT, PREGNANCY & SAMPLE INFORMATION

FIRST NAME*	SURNAME*	DATE OF BIRTH* (DD/MM/YYYY)
PATIENT ADDRESS	**PATIENT POSTCODE**	**PATIENT TELEPHONE**
MATERNAL WEIGHT (KG)	**MATERNAL HEIGHT** (CM)	**MEDICAL RECORD NO.**
ULTRASOUND DATE* (DD/MM/YY)	**BLOOD DRAW DATE*** (DD/MM/YY)	**GESTATION AT DRAW*** (WEEKS + DAYS)

PREGNANCY TYPE* ☐ Single ☐ Dichorionic Twin ☐ Monochorionic Twin

VANISHING TWIN (IF APPLICABLE) ☐ Yes

REPEAT SAMPLE (IF APPLICABLE) ☐ Yes

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

PATIENT, PREGNANCY & SAMPLE INFORMATION

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

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

PREVIOUS NO. OF PREGNANCIES

PREVIOUS NO. OF MISCARRIAGES

EXPECTANT MOTHER AFFECTED BY/HAS UNDERGONE*

- ☐ Immunotherapy *(excluding intravenous immunoglobulin (IVIg) treatment)*
- ☐ Maternal genetic condition *(please give details)*
- ☐ Organ transplant/Stem cell therapy
- ☐ Recent transfusion *(<4 months)*
- ☐ Tumour/Fibromas *(please give details)*

MEDICAL NOTES *Provide details of relevant medical history, 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**[2]	**Chromosomes 21, 18, 13, X, Y**
☐	**Prenatalsafe® 5 DiGeorge**	**Chromosomes 21, 18, 13, X, Y + DiGeorge syndrome**
☐	**Prenatalsafe® Plus**	**Chromosomes 21, 18, 13, X, Y + panel 6 Microdeletions + Trisomies 9 + 16**
☐	**Prenatalsafe® Karyo**	**Genome-wide NIPT that provides karyotype-level insight**
☐	**Prenatalsafe® Karyo Plus**	**Genome-wide NIPT that provides karyotype-level insight + panel 9 Microdeletions**
☐	**Prenatalsafe® COMPLETE**[3]	**Prenatalsafe® Karyo + Genesafe Complete (Father's sample required)**
☐	**Prenatalsafe® COMPLETE Plus**[3]	**Prenatalsafe® Karyo Plus + Genesafe Complete (Father's sample required)**
☐	**Prenatalsafe® Full Risk**[3]	**Prenatalsafe® Karyo Plus + Genesafe Complete + Genescreen Focus (Father's sample required)**

UK/IE

ITALY[1]

DO YOU WISH TO KNOW THE FETAL SEX? *, [4] ☐ YES ☐ NO

[1] Referred to the specialised genomics laboratory Eurofins Genoma, Via di Castel Giubileo, 62, 00138 Roma RM, Italy (Prenatalsafe Karyo is accredited to ISO: 15189). See patient information leaflet for more information.
[2] Sex chromosome aneuploidies are not reported for twin pregnancies (including single with vanishing twin). A Prenatalsafe 3 report will be issued instead.
[3] Add father's information for test type Prenatalsafe® COMPLETE, Prenatalsafe® COMPLETE Plus, Prenatalsafe® Full Risk, see next page.
[4] 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.

eurofins

PLEASE TURN OVER

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REQUEST & CONSENT FORM

PLEASE WRITE CLEARLY USING CAPITAL LETTERS

*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)**.

☐ YES ☐ NO	I consent to the use of leftover specimen and for anonymised health information to be stored and used for the development or enhancement of future non-invasive testing.

Full Name (USE CAPITAL LETTERS)

X _____

Signature Date: DD/MM/YYYY

X _____

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 information leaflet.
- I have taken and packed the sample in accordance with the kit instructions.

BILLING (IF APPLICABLE)

☐ Patient ☐ Clinic/Consultant

Payment Confirmation No. _____

Full Name (USE CAPITAL LETTERS)

X _____

Signature Date: DD/MM/YYYY

X _____

[3] FATHER'S INFORMATION (For test type Prenatalsafe® COMPLETE, COMPLETE Plus, Full Risk)

FIRST NAME	SURNAME	DATE OF BIRTH (DD/MM/YYYY)

ADDRESS	SAMPLE TYPE	DATE OF SAMPLE COLLECTION (DD/MM/YY)
	☐ EDTA blood ☐ Buccal swab	

FATHER'S 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.

Full Name (USE CAPITAL LETTERS)

X _____

Signature Date: DD/MM/YYYY

X _____

To withdraw any of the consents above, please email: **UK**: GeneticEnquiriesUK@ctuk.eurofins.com /**IE**: ClientServices@ctie.eurofinseu.com

CONTACT INFORMATION – Eurofins Clinical Genetics:
UK: 90 Pristley Road, Surrey Research Park, Guildford, Tel +44(0)7501805142
IE: Unit 3, Sandyford Business Centre/Business Park, Blackthorn Rd, Dublin 18, D18 E528, Tel 1800 252 966

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