SW THAMES REGIONAL GENETICS LABORATORY
REQUEST FOR PRENATAL TESTING

St George's Healthcare NHS
NHS Trust

PATIENT NAME: ……..
DOB: …… Consanguinity (if Known): YES/NO
ADDRESS:……
……
……
NHS number: ……..

Referring Consultant……..

HOSPITAL:……..

HOSPITAL NUMBER/FMU number: ……..Form completed by: ..……

Referring Geneticist / Counsellor:…….....Sample taken on:

Number of Fetuses: …… Gestation (by ultrasound): ……..weeks

Maternal serum screening result/NIPT: ……

Fetal Sex on Ultrasound: Male/Female/Unknown

Nuchal measurement: …… (First Trimester / Second Trimester)

Ultrasound abnormality: YES/NO ……

Report Enclosed: YES/NO

Other test indication: …… (i.e. previous trisomy/TTTS/IUD)

SAMPLE TYPE:	CVS	Amnio	FBS	Other

TEST:	QFPCR	+Array	+karyotype/FISH	+DNA test (please specify)

DNA storage: YES/NO Sample to virology: YES/NO TOP: YES/NO

FOR LAB USE ONLY

Sample number:		Date received:	
QFPCR result:		Date:	
Reviewed by:		Fetal sex	Male / female

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Referring Hospital:

Fetal Medicine Unit

Consent for Invasive Prenatal Diagnostic Testing and Subsequent Genetic Analysis

Prenatal diagnostic test

1. Involves the insertion of thin needle into the womb to take a small sample from the amniotic fluid, placenta or umbilical cord ☐

2. The prenatal diagnostic test is a risk associated with a miscarriage risk of ~1%. ☐

3. There is a small risk of laboratory failure to obtain a result. This may cause a delay in the reporting of a result or require repeat testing. ☐

Array testing

1. I have read the prenatal array CGH leaflet and had the opportunity to ask the midwife questions about the test. ☐

2. I agree to analysis of my baby's DNA by array CGH to identify chromosome imbalances that may explain the abnormal ultrasound findings in my baby ☐

3. I understand that rarely, we may be contacted about chromosome imbalances unrelated to the abnormal ultrasound findings, but which may cause a susceptibility to medical problems after birth. ☐

Patient Name:…… Signature: ……

Health Professional Name:…….. Signature……

Date: ……