

### Woman's Information

First Name

Last Name

Date of Birth (DD/MM/YYYY)

Address

City

Postcode

NHS Number  Hospital Number

Ethnicity

<input type="checkbox"/> <b>A</b> White British	<input type="checkbox"/> <b>K</b> Bangladeshi
<input type="checkbox"/> <b>B</b> Irish	<input type="checkbox"/> <b>L</b> Any other Asian background
<input type="checkbox"/> <b>C</b> Any other White background	<input type="checkbox"/> <b>M</b> Caribbean
<input type="checkbox"/> <b>D</b> White and Black Caribbean	<input type="checkbox"/> <b>N</b> African
<input type="checkbox"/> <b>E</b> White and Black African	<input type="checkbox"/> <b>P</b> Any other Black background
<input type="checkbox"/> <b>F</b> White and Asian	<input type="checkbox"/> <b>R</b> Chinese
<input type="checkbox"/> <b>G</b> Any other mixed background	<input type="checkbox"/> <b>S</b> Any other ethnic group
<input type="checkbox"/> <b>H</b> Indian	<input type="checkbox"/> <b>Z</b> Not stated
<input type="checkbox"/> <b>J</b> Pakistani	<input type="checkbox"/> <b>99</b> Not known

Weight (kg) at time of NIPT sample collection

### Confirmation of eligibility

Please confirm the following have been considered and excluded (tick Yes if excluded):

• maternal cancer (unless in remission)	<input type="checkbox"/> No <input type="checkbox"/> Yes
• blood transfusion in the last 4 months (whole blood or plasma)	<input type="checkbox"/> No <input type="checkbox"/> Yes
• bone marrow or organ transplant recipient	<input type="checkbox"/> No <input type="checkbox"/> Yes
• vanished twin pregnancy (an empty second pregnancy sac or a second pregnancy sac containing a non-viable fetus)	<input type="checkbox"/> No <input type="checkbox"/> Yes
• maternal T21	<input type="checkbox"/> No <input type="checkbox"/> Yes
• balanced translocation or mosaicism of T21, T18 or T13	<input type="checkbox"/> No <input type="checkbox"/> Yes
• immunotherapy in the current pregnancy, excluding IVIg treatment	<input type="checkbox"/> No <input type="checkbox"/> Yes
• stem cell therapy	<input type="checkbox"/> No <input type="checkbox"/> Yes

Further clinical details that require discussion with the NIPT laboratory prior to obtaining sample:

Does the following apply to the woman?

• any known chromosomal or genetic condition other than T21, T18 or T13 in pregnant woman	<input type="checkbox"/> No <input type="checkbox"/> Yes
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If Yes, please contact the laboratory to discuss prior to obtaining the sample.

### Clinic Information

Hospital Name and 5 Digit ODS Code

Ordering Clinician

Address

City

Postcode

Phone

NHS Email

Referring Clinician

### Screening options requested

T21, T18, T13     T21 only     T18 and T13 only

### Essential clinical information\*

Gestational age at NIPT sampling date by ultrasound \_\_\_\_\_ weeks \_\_\_\_\_ days

EDD by ultrasound (DD/MM/YYYY) \_\_\_\_\_

Number of Fetuses\*  1  2

IVF Pregnancy?\*  No  Yes

Chorionicity for twin pregnancy

Monochorionic     Dichorionic     Unknown

Type of screening:  Combined     Quad

T21 screening chance result: 1 in \_\_\_\_\_

Joint T18 and T13 screening chance result: 1 in \_\_\_\_\_

Is this a repeat sample?  No  Yes

Reason for repeat sample \_\_\_\_\_

Previous T21, T18 or T13?  No  Yes (please print which condition)

### IMPORTANT BLOOD DRAW INFORMATION

**Sample requirements**

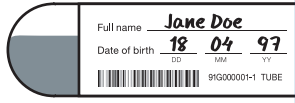
- Minimum of 6.5ml of maternal blood in cell stabilising tube.
- The tube should be gently inverted 10 times after blood draw.
- Do not refrigerate.
- Send to NIPT laboratory as soon as possible following sample collection.
- Inform the NIPT laboratory that a sample is on its way.
- Laboratory to confirm receipt of sample.

**Complete A & B:** (DD/MM/YYYY)

A. Blood collected on: \_\_\_\_\_ by: \_\_\_\_\_

B. Write the woman's full name and date of birth on tube barcode label. →

Name, barcode and date of birth must match the Request Form. Place label lengthwise on the cfDNA tube as shown in the example.



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Full name **Jane Doe**

Date of birth **18 04 97**

91G000001-1 TUBE