eurofins | Biomnis

Test request form
Antenatal diagnostics
on invasive sampling

INTERNATIONAL DIVISION

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Request Identification
Request Form Number
(Numéro du patient)

Your reference
(Référence)

.....

Customer Identification

Compulsory Stick
your laboratory identification sticker here

PATIENT

First name(s)*: .....
Surname*:.....
Maiden name*: .....
Address*: .....
Post code*: ..... City*: .....
Country*: .....
Tel.*: |__|__|__|__|__|__|__|__|__|__|
Date of birth*: |__|__| |__|__| |__|__|__|__|
Date of last period*: |__|__| |__|__| |__|__|__|__|
Expected due date: |__|__| |__|__| |__|__|__|__|

Name of spouse : .....
Date of birth: |__|__| |__|__| |__|__|__|__|

**Champs obligatoires*

CLINICAL DETAILS, MEDICAL BACKGROUND

Has the patient had more than three miscarriages: ☐ OUI ☐ NON
Are there any known genetic diseases in the family: ☐ OUI ☐ NON
If yes, please specify: .....
.....
.....
.....
.....
.....

PRESCRIBER

First name(s): .....
Surname:.....
Address: .....
Post code: ..... City: .....
Country: .....
Tel.: |__|__|__|__|__|__|__|__|__|__|
Fax: |__|__|__|__|__|__|__|__|__|__|

PRACTITIONER

Client number: .....
First name(s): .....
Surname:.....
Address: .....
Post code: ..... City: .....
Country: .....
Tel.: |__|__|__|__|__|__|__|__|__|__|
Fax: |__|__|__|__|__|__|__|__|__|__|

Practitioner stamp

INFORMATION AND CONSENT FOR PREGNANT WOMEN

for the collection of a sample and the performance of one or more tests for the purposes of prenatal diagnostics in utero (as per Article R. 2131-1 of the French Public Health Code)

I, the undersigned, ... ▸ **confirm that**

the doctor *(Surname, First Name)* : .....

as part of a medical consultation on (date): |__|__| |__|__| |__|__|

I received the following:

1. Has given me information about:

- the risk of the unborn child being born with a particularly serious condition;
- the characteristics of this condition;
- the means of diagnosing it;
- the possible opportunities offered by foetal medicine for the treatment or care of the child after birth;

2. Has given me information on the laboratory tests that could establish a prenatal diagnosis in utero; these tests have been offered to me and I wish to receive them:

- this (these) test(s) require(s) a sample of amniotic fluid, chorionic villi (placenta), foetal blood, or other foetal sample;
- the methods, risks, constraints and possible consequences of each sampling technique needed to perform this (these) test(s) have been explained to me;
- I have been informed that a second sample may be needed in the event of technical failure; in this event, I will need to sign a new written consent form;
- I have been informed about possible conditions other than those initially investigated that could be revealed by the examination;
- I have been informed that the result of the test will be given to me and explained by the doctor who prescribed it to me.

I give my consent for the sampling of (required for the conduct of the test(s)) (*):

- amniotic fluid
- chorionic villi
- foetal blood
- other foetal sample (please specify)

I also give my consent for the test or tests (*) for which the sample is being collected:

- cytogenetic tests, including molecular tests applicable for cytogenetics
- molecular genetics tests
- foetal biochemistry tests for diagnostic purposes
- laboratory tests for the diagnosis of infectious diseases

This (or these) test(s) will be carried out in a medical laboratory that is duly authorized by the regional health agency to conduct them.

The original copy of this document will be stored in my medical records.

A copy of this document will be given to me and to the person responsible for conducting the tests.
The medical laboratory in which the person responsible for conducting the tests is employed shall keep this document under the same conditions as the report of the examination.

(*) Delete as applicable

Date : |__|__| |__|__| |__|__|

Signature of the clinician	**Signature of the interested party**

- **Sample date :** ☐☐/☐☐/☐☐☐☐

Weeks of amenorrhea: ☐☐

- **Sample type**

☐ Amniotic fluid **(CLA ou CHN)**

Tube 1 ▸ Volume: ..... mL
▸ Appearance: ☐ clear ☐ brown ☐ bloody

Tube 2 ▸ Volume: ..... mL
▸ Appearance: ☐ clear ☐ brown ☐ bloody

☐ Chronic villi sampling **(CVS)**
☐ Products of conception **(SNPFC)**
☐ Fœtal blood **(FB)**
☐ DNA extracted from: .....
(specify the nature of the sample)

In cases of twin pregnancy, please indicate the number of fœtus sampled: .....

TEST REQUEST

☐ FETAL STANDARD KARYOTYPE

☐ **FETAL DNA MICROARRAY (SNP ARRAY) (SNPRE)** - *Please supply **5 mL EDTA maternal blood sample***
☐ High risk of trisomy 21 by Maternal Serum Test - *The report must be supplied*
☐ Positive NIPT - *The NIPT must be supplied*
☐ Ultrasound abnormalities - *The ultrasound report must be supplied*
☐ Parental chromosomal anomalies - *The report must be supplied*
☐ The couple has a previous history of pregnancy with an abnormal karyotype - *The report must be supplied*
☐ Advanced maternal age
☐ Personal request: .....
☐ Other: .....

☐ *IN SITU* HYBRIDISATION (FISH)

- **Rapid diagnosis on uncultivated nuclei:** ☐ Chromosome 21 **(FISHN)** ☐ Chromosomes 13, 18, 21, X, Y **(FISHN)**
- **Microdeletion screening** - *Please specify:* .....

For any additional request, it is highly recommended to take a third tube according to the term of pregnancy.

☐ FŒTAL BIOCHEMISTRY

☐ Alpha fetoprotein (αFP) **(AFPLA)** ☐ Acetylcholinesterase (AChE) **(ACOLA)** ☐ Digestive enzymes
☐ Other: .....

FŒTAL INFECTION PROFILE

- **Indication:**

Ultrasound signs : ☐ YES ☐ NO If yes, please specify: .....
Seroconversion: ☐ YES ☐ NO If yes, date of pregnancy at the time of seroconversion: ☐☐/☐☐/☐☐☐☐

- **Desired pathogens:**

☐ Cytomegalovirus **(CMVLA*)** ☐ Parvovirus B19 **(PARLA*)** ☐ Toxoplasmosis **(TOXLA*)** ☐ HSV1/HSV2 **(HSVLA*)**
☐ Rubella **(RUBLA**)** ☐ Varicella Zoster **(VZVLA*)** ☐ Other: .....

** 8mL, amniotic fluid, refrigerated*
***5mL (minimum), amniotic fluid, frozen 4h*

☐ Zika **(ZIKLA*)** ▸ Stay in endemic areas: ☐ YES ☐ NO If yes, return date: ☐☐/☐☐/☐☐☐☐
▸ Spouse presenting a positive sample for Zika: ☐ YES ☐ NO

Please supply the maternal serology results and the date of seroconversion as well as the latest ultrasound report..

☐ MOLECULAR GENETICS

*For all test requests, please supply **5 mL EDTA maternal blood sample** and **5 mL EDTA paternal blood sample.***

☐ Uniparental disomy **(DUPRE)**
Which chromosomes 7, 14, 15: .....
☐ Mono-/di-zygotic (twins) **(ZYGO)**
☐ Cystic fibrosis (CFTR, screening for most common mutations) **(MUCOL)**: *(see specific file available on **www.eurofins-biomnis.com**)*
☐ Prader-Willi syndrome **(SNRPL)**

☐ qPCR: *contact us* **(QPRE)**
(attach the R66-INTGB information form)
☐ Sanger: *contact us* **(SEPRE)**
(attach the R66-INTGB information form)
☐ Fragile X syndrome **(XFRAP)**
☐ Exome *(specific request form required, please see www.eurofins-biomnis.com)*
☐ Other: .....

Documents
- Test request form indicating which tests to be performed