Ninalia
by eurofins biomnis

Test Request form
Detection of chromosomal abnormalities
by analysis of circulating cell-free DNA (NIPT)

PRESCRIBING CLINICIAN

First name(s): ..... Surname: .....
Address: .....
Post code: |_|_|_|_|_| City: .....
Country: .....
Tel.: |_|_|_|_|_|_|_|_|_|_| Fax: |_|_|_|_|_|_|_|_|_|_|
Email: .....
Date: |D|D|M|M|Y|Y|Y|Y|

Clinician's stamp

Protocol no. (internal use only)

Signature :

PATIENT

First name(s): .....
Surname: .....
Name of birth: .....
Date of birth: |D|D|M|M|Y|Y|Y|Y|

Adresse : .....
Post code: |_|_|_|_|_| City: .....
Country: .....

REQUIRED INFORMATION

Gestational age at draw: Weeks: ..... Days: .....
Gestational age calculated by Ultrasound: ..... Date: |D|D|M|M|Y|Y|Y|Y|
Vanishing twins: ☐ YES ☐ NO
Number of live fetuses:..... Please precise if ultrasound abnormalities: .....

INDICATION FOR TESTING

☐ Primary screening
☐ Parental wish
☐ Twin pregnancy
☐ History of pregnancy with trisomy 21, 18 or 13
☐ 2nd draw
☐ Couple where one of the members carries a Robertsonian translocation involving chromosomes 13 or 21
☐ Maternal Serum Markers screening: ☐ 1st term ☐ 2nd term Risk 1/ .....
☐ Other: .....

TEST REQUESTED *(please tick 1 of the 4 boxes)*

☐ **Ninalia 3 (NIPT):** Trisomies 21, 18 et 13

☐ **Ninalia 5 (NIPT):** Trisomies 21, 18 et 13
+ Fetal gender determination
+ Sex chromosomes aneuploidies

☐ **Ninalia Genomewide (NIPT):** all autosomes
+ chromosomal imbalance greater than 7Mb

☐ **Ninalia Genomewide Complete (NIPT):** all autosomes
+ Chromosomal imbalance greater than 7Mb
+ Sex chromosomes aneuploidies
+ Fetal gender determination

PATIENT CONSENT

I consent to the test(s) I have chosen 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 the results should be reviewed by my healthcare provider. I have had the opportunity to ask questions and understand that I can request further information and genetic counselling.

I consent to the use of the leftover specimen and health information in the Patient Informed Consent document.

I agree that my personal data may be used for auditing and quality control purposes as outlined in the Patient Informed Consent document and understand I can withdraw my consent at any point.

Date: |D|D|M|M|Y|Y|Y|Y|

Patient's signature

PRESCRIBING CLINICIAN CONSENT

I verify that the patient and prescriber information in this form is complete and accurate to the best of my knowledge and 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, and I agree to provide it as needed.

Date: |D|D|M|M|Y|Y|Y|Y|

Prescribing clinician's signature

LABORATORY

This test requires a Streck blood collection tube (kit K39).
Samples must reach Eurofins Biomnis within 5 days maximum of collection.
To receive the sample kit and manage the transportation of the sample, please contact Biomnis International Division at: +33 4 72 80 23 85 or via email at: international@biomnis.eurofinseu.com

Blood sample taken on: |D|D|M|M|Y|Y| at |_|_| hr |_|_| min

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