

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

PRESCRIBING CLINICIAN	l			Protocol no. (internal use only)
First name(s):				
Address:		isian's stamp.		
Post code: City:	Cli	hUlcie.	L	
	Fax:			Signature :
Email:				
Date: $D_1D_1M_1M_1Y_1Y_1Y_1Y_1$				
PATIENT				
First name(s):		Adresse :		
Surname:		Post code:		City:
Name of birth:				
Date of birth: $D_1 D_1 M_1 M_1 L_1 L_1$				
REQUIRED INFORMATION	1			
Gestational age at draw:	Weeks: Days	S:		X
Gestational age calculated by Ultrasound: Date: D,D,M,M,Y,Y,Y,Y,Y				
Vanishing twins: YES NO				
Number of live fetuses: Please precise if ultrasound abnormalities:				
	G			
Primary screening				
Twin pregnancy				
History of pregnancy with triso	my 21, 18 or 13			
2 nd draw				10 01
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at: international@biomnis.eurofinseu.com

Blood sample taken on: <u>D</u>, D, M, M, Y, Y, at <u>I</u>, hr <u>I</u>, min