	ITIAL DOCUMENT THE PATIENT'S MEDICAL CONDITION
eurofins Biomnis Ge	Clinical Information Form enetic fœtalblood typing
NTERNATIONAL DIVISION 17/19, avenue Tony Garnier • BP 7322 Fel.: +33 (0)4 72 80 23 85 • Fax: +33 (0)4 72 80 73 56 • E-mail : inter	
Referring laboratory	PRESCRIBING CLINICIAN/ESTABLISHMENT
	First name(s): Surname: Address:
PATIENT DETAILS	Postcode: L City:
First name(s): Surname:	
Vaiden name:	Stamp and signature required
Please attach a photocopy	of the patient's blood group card
TEST(S) REQUESTED (WA = WEEKS OF AMENORRHOEA	A)
RH1 (D) from 12 WA RH3 (E) from 13 WA RH4 (C) from 13 WA KEL1 (Kell) from 13 WA MATERNAL BLOOD Sample requirements: 3 tubes of 5 - 7 mL of EDTA whole blood	RH1 (D) RH3 (E) RH4 (little-c) KEL1 (Kell) AMNIOTIC LIQUID Sample: 5 mL in a sterile tube
Turn-around-time: 72 hrs (RH1)/48 hrs (KEL1) Sample collection date: Name of phlebotomist: If an amniocentesis is planned: Date :	Turn-around-time: 72 hrs Sample collection date: Reason for amniocentesis: Cytogenetics laboratory:
Please specify the family's geographic origin:	
• Father:	Mother:
Please specify the father's RH-KEL1 phenotyping:	
☐ To diagnose foetal-maternal incompatibility for a pregnancy und ☐ For non-immunised Rh negative patients: to evaluate if antenata I, the undersigned, Miss/Ms/Mrs	al Rh-immune prophylaxis testing is necessary. accept that the test offered is performed on foetal DNA, within an autho- ar 2006 concerning prenatal diagnostics, and that a part of the sample is to
I declare that I have understood that the testing method could rend borderline preliminary result could lead to a second maternal blood	der a excessively positive result (or false positive), and that a negative or d sample being requested for confirmation.
	Signed in (city): On (date)
Prescribing clinician's signature	Patient's signature
These tests a	re subject to referral.