Wellington Regional Genetics Laboratory

Level 6, WSB, Wellington Hospital
Phone: 04-918-5352
Fax: 04-385-5822
Email: wrgl@ccdhb.org.nz
Website: www.wellingtongenetics.co.nz

IANZ

PRENATAL DIAGNOSIS LABORATORY REQUEST FORM

PATIENT & REFERRER

(to be completed by the obstetrician)

Patient Name: ………………………………………………………

Patient DOB: ………………… NHI No: …………………..

Address: ……………………………………………………………

Consultant's location: ……………………………………

Obstetrician: ………………………………………………

Ph: ………………….. Fax: ……………………..

Lead Maternity Provider: …………………………..

Ph: ………………… Fax: ……………………..

Additional copies of report to: ……………………………………………………………………………………

FAMILY / PREGNANCY HISTORY

(to be completed by the obstetrician)

Father of Pregnancy Name: ………………………………………………… D.O.B. ……………………….

No. of previous pregnancies: ……………… No. of children: ………….. Miscarriages: ………………

Amnio/CVS in previous pregnancy? ☐ Yes ☐ No Under what name/where:…………………………………

Previous children with abnormality? ☐ Yes ☐ No Specify: ……………………………………………..

INDICATION FOR TEST

LMP: ………………….. EDD: ……………. Scan gest at sampling: ………………..

Screening risk 1: ………… determined by:

☐ NT alone ☐ 1st Trimester Combined (MSS1+NT) ☐ MSS2 ☐ Integrated (MSS1+NT+MSS2) ☐ Other

☐ Maternal age alone

☐ Anxiety

☐ Nuchal translucency measurement mm: …………

☐ Previous chromosomal abnormality: specify: …………………………………………………………………...

☐ Family translocation: specify: ……………………………………………………………………………

☐ Abnormalities on scan: specify ……………………………………………………………………………

☐ Other ……………………………………………………………………………………………………

TEST

☐ Chromosome analysis

☐ QF-PCR Rapid Aneuploidy Detection ***

☐ 22q FISH (heart defects)

SAMPLE

☐ CVS Weight (est): ………. Sample condition ……………..

☐ Amniocentesis Volume: …………… Clear ☐ Bloodstained *** ☐

***** for blood-stained samples also send 4ml EDTA maternal blood** ☐

For lab use only:

Obstetrician's signature: ………………………………

Date of Sample: ……………………………