Universitair Ziekenhuis Brussel

Hôpital Erasme

ULB

ULB Center of Human Genetics

version6/20170701

REQUEST FORM GENETIC ANALYSIS NON-INVASIVE PRENATAL TEST (NIPT)

CENTRE FOR MEDICAL GENETICS

UZ Brussel

Laarbeeklaan 101 - 1090 Brussels

secretary laboratory: phone +32 (0)2 477 64 79 - fax +32 (0)2 477 68 59

secretary consultation: phone +32 (0)2 477 60 71 - fax +32 (0)2 477 68 60

www.brusselsgenetics.be

BELAC 141-MED **BELAC 141-MED accreditation according to quality norm ISO15189:2012**

A separate form has to be filled completely in CAPITALS per patient.
A genetic test will only be started after receipt of a fully completed request form signed by both the patient and referring physician

Identification of patient

Surname patient:
First name patient:
Date of birth:
Address:

National number:
Health insurance:
Membership Nr:
UZ Brussel file Nr:
Family Nr:
Ethnic origin:

identification label patient

Identification of referring physician

Surname physician:
First name physician:
Referring service:
Address:

E-mail:
Medibridge:
Phone:
RIZIV/INAMI Nr:
Date request*:
Your reference:
Copy result to:
Address:

stamp referring physician

Language of choice for report ☐ English ☐ French ☐ Dutch

Pregnancy data

Before pregnancy:

Length (cm): _____ Weight (kg): _____ BMI: _____

Pregnancy:

☐ Spontaneous ☐ after IVF ☐ after ICSI ☐ after PGD ☐ Oocyte donor

Ultrasound:

Date: ...../...../..... Attention! NIPT is less reliable before 12 weeks of pregnancy

Number of weeks pregnant: _____ weeks _____ days

Signs: ☐ Absent
☐ Suggestive for trisomy 21
☐ Suggestive for other (numerical) anomaly
Description: _____

Nr of foetuses: ☐ 1 ☐ 2 ☐ vanishing twin

Chorionicity: ☐ DC/DA ☐ MC/DA ☐ MC/MA

Attention! NIPT and sex determination is less reliable in case of a (vanishing) twin

History

Pregnancy/ies: G: ___ P: ___ A: ___ ☐ Miscarriage ☐ TOP ☐ Extra uterine ☐ Molar

History of genetic condition:

☐ In previous pregnancy: _____
☐ In patient: _____
☐ In family: _____

History of pregnant patient:

☐ Medical: _____ Date: ...../...../.....
☐ Surgical: _____ Date: ...../...../.....
☐ Medication/therapy: _____
_____ Date: ...../...../.....
☐ Other: _____
_____ Date: ...../...../.....

Sample information

☐ 1st 1x 10 mL blood in Streck tube

Attention! minimally 8 mL blood/tube and inversion of tube directly after sampling is required
Conservation and transport: at room temperature maximum 1 day / at cooling temperature up to 4°C if > 1 day - freezing should be absolutely avoided

Date of sampling: _____ Hour of sampling: _____

Date of receipt: _____ Hour of receipt: _____

Informed consent of pregnant patient

1. I have been informed about the possibilities and limitations of this test, as described in the information leaflet. I have had the opportunity to request additional information from my physician.
2. I understand that this test is intended for the detection of trisomy 21, 18 and 13, from the 12th week of pregnancy onwards. Other, more appropriate tests may be offered when there is an increased risk of certain genetic disorders.
3. In the case of a normal result, the probability that the foetus still has trisomy 21, 18 or 13 is very small, but cannot be completely excluded. An abnormal test result should be confirmed by an invasive prenatal test (amniocentesis).
4. The result will usually be available within 4 days after receipt of the blood sample.
5. In approximately 5 % of cases, results cannot be obtained. In this case, a new blood sample can be tested without any extra costs.
6. I understand that the cost of this test is 260 EUR (+possible indexation), of which a maximum of 8,68 EUR will be charged to me.
7. In certain cases, NIPT can detect chromosome abnormalities of clinical significance other than trisomy 21, 18 or 13. In this case, the "Centres for Medical Genetics (of UZ Brussel and/or Erasme)" will contact my gynaecologist so that further monitoring of the pregnancy can be modified according to the findings.

Patient

I understand the above information and I agree that genome wide NIPT will be performed for the detection of foetal trisomy 21, 18 and 13

☐ I do not want to be informed about relevant chromosomal abnormalities other than trisomy 21, 18 and 13.

Name: _____
Date: _____

Signature: _____

Referring physician

I have informed the patient about the possibilities and limitations of genome wide NIPT for the detection of foetal trisomy 21, 18 and 13

Name: _____
Date: _____

Signature: _____