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Site : www.ipg.be

n° réception IPG	n° analyse IPG

REQUEST FORM FOR GENETIC NON INVASIVE PRENATAL TEST FOR TRISOMY 21, 18 AND 13 (received accreditation ISO-15189 (MED-381)

DETAILS OF THE MOTHER

Surname:
First name:
Date of birth:
Phone number (facultative):
Complete address:
Street and number:
Post code and town:
Health Insurance Nr: ☐☐☐ ☐☐☐ ☐☐☐ ☐☐☐
National Insurance Nr: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Predicted date of delivery: ……/……/……

Pregnancy:
☐ single
☐ twin ☐ (DC/DA) ☐ (MC/DA) ☐ (MC/MA)

Weight before pregnancy: ……
Height: ……
Sex of the fœtus on sonography ☐ male ☐ female ☐ unknown

REFERRING PHYSICIAN

Surname:
First name:
Hospital/Institution:
Street and number:
Post code and town:
Phone number:
Inami nr:
Stamp/Signature :

Copy to:

Address:

Reception:
- Date: ……/……/……
- Time: ……h……

SAMPLE

From Monday to Thursday - For enquiries : ☎ : 071/44.71.81

1 Cell-Free_DNA_BCT tube of the brand Streck 10 ml

(filled with **minimum of 8 ml** of maternal blood in order to obtain sufficient foetal DNA).

Sample : Date : ……/……/ …… Time : ……h ……

The sample should be sent to the laboratory **as quickly as possible (< 24 h)**
Do not freeze and keep at room temperature.

MEDICAL HISTORY

Gravidity: …… Parity: …… Miscarriages: ……

Interruptions of pregnancy: ……

Previous pregnancies with chromosomal abnormalities (to be detailed):

Family or personal history of genetic disorders (to be detailed):

Previous history of transfusion, transplantation, stem cell therapy, cancer (to be detailed):

AGE OF PREGNANCY (*)

☐ Age of pregnancy: …… WA (min 12 WA)

☐ Sonography T1:

(*) The screening is reimbursed only from the 12th week of pregnancy

TEST RESULTS TRANSMISSION

☐ MEXI ☐ Fax nr …… (To be completed only at 1st prescription)

Non conformity code: ……
Initials LT

CONTACT

Form can be downloaded at : http://www.ipg.be/

See obligatory informed consent (verso)

INFORMED CONSENT*

1. I understand, the indication, the purpose, benefits and limitations of this test. My doctor, Dr _____, answered all my questions.

2. I understand that this test is only used to detect trisomy 21, 18 and 13 in the fetus from 12 weeks of pregnancy. I also understand that this test is very accurate, but not 100%. In case of a normal result, the risk that the baby has trisomy 21, 18, or 13 is very small, but not entirely excluded. Others chromosomal abnormalities can be found at the fetal or maternal level but this test has not been validated for the detection of these types of abnormalities.

3. I was informed that the result will be available within 1 week following receipt of the sample.

4. I understand that in some cases (about 5%), a result cannot be obtained with the first blood sample. A new blood sample may be necessary due to unforeseen circumstances, including insufficient fetal DNA concentration in the blood sample, sample degradation during transportation,.... If this occurs, a new blood test can be performed and analyzed at no extra cost.

5. I understand that the result should not be considered as a diagnosis. A positive result, indicating an increased risk, should always be confirmed by a diagnostic test, such as a puncture of the amniotic fluid (from the 15th week pregnancy).

6. I agree to provide relevant information regarding the pregnancy, such as any chromosomal anomaly or genetic disorder in the family. I understand and agree that my doctor can contact me to request such information.

7. I was informed that this test is reimbursed since July 1th 2017 and that I will have to pay the user fee of 8,68 €.

8. This test is ISO-15189 (MED-381) accreditated since April 2015.

9. The NIPT test is established on basis of the Belgian Society of Human Genetics (BeSHG) recommendations. These lasts can be found on the net: http://www.beshg.be/index.php?page=guidelines sections “Summary of NIPT guidelines” and “NIPT guidelines for incidental findings”.

10. This informed consent can be explained and then signed after genetic counselling by a specialized medical doctor. In this case, the payment of a supplement for this medical appointment will be asked.

I AGREE THAT THIS TEST IS PERFORMED
FOR THE PRENATAL DETECTION OF TRISOMY 21, 18 AND 13.

PATIENT	PHYSICIAN
Name: _____	Name: _____
Date: _____	Date: _____
Signature*: _____	Signature*: _____

(*) *Mandatory signature for analysis*