



# Non-Invasive Prenatal Test | Request Form

## FOR THE DOCTOR

This test should be requested by the doctor responsible for managing a woman's decision-making regarding Non-Invasive Prenatal Testing.

### Patient details

First name \_\_\_\_\_ Surname \_\_\_\_\_

Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender **Female – Pregnant**

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone (mobile) \_\_\_\_\_

### Test/s requested

#### SINGLETON

Harmony™ Prenatal Test T21, T18, T13

Monosomy X

Fetal gender

Sex chromosomes aneuploidy panel

#### TWIN

Harmony™ Prenatal Test T21, T18, T13

Fetal gender (detects presence of one or two male twins)

Is this a  **RECOLLECTION?** Previous Lab ID \_\_\_\_\_

## Clinical information

**REQUIRED**

**ALL fields must be completed for testing to proceed.**

**Note** If any of the clinical information changes, the lab must be notified as the data captured below is included in the test algorithm.

### GESTATIONAL AGE

Either Weeks \_\_\_\_ Days \_\_\_\_ as at \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (date)

or  LMP  EDC  IVF \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (date)

### CONCEPTION DETAILS

Natural  IVF (Patient egg) | Maternal age at egg retrieval \_\_\_\_ yrs

IVF (Donor egg) | Maternal age at egg retrieval \_\_\_\_ yrs

### MATERNAL INFORMATION

Maternal weight (kg) \_\_\_\_\_ Maternal height (cm) \_\_\_\_\_

Harmony™ Prenatal Test is not validated for 3 or more fetuses, or in the presence of a demised fetus. The Harmony™ Prenatal Test examines for certain aneuploidies in viable singleton and twin pregnancies by natural or IVF conception after 10 weeks' gestation. Specific exclusions are detailed at [www.sonicgenetics.com.au](http://www.sonicgenetics.com.au). Please note that the requested clinical information is essential for test accuracy.

## Requesting doctor

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_ Provider No \_\_\_\_\_

I confirm that this patient has been counselled about the purpose, scope and limitations of the test and has given consent.

Signature  **CLINICIAN SIGNATURE** Date \_\_\_\_\_

## Copy reports to

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

## FOR THE PATIENT – Patient consent

I consent to the Harmony™ Prenatal Test being performed and confirm that I have been informed about the purpose, scope, and limitations of the test by my doctor, patient literature and/or the Sonic Genetics website. I understand that the test is a screen for selected abnormalities of chromosomes 21, 18 and 13; that the test can also screen for less serious selected abnormalities of the sex chromosomes, and identify fetal gender; that the result should be reviewed by my doctor in the light of other findings; that a 'high-risk' result should be confirmed by fetal karyotype; that a second collection may be required; and that 1-2% of tests do not yield a result due to biological factors (with prepaid tests for chromosomes 21, 18, and 13 being refunded). I have had the opportunity to ask questions and understand that I can request further information or genetic counselling.

I consent to my identified result being used with Government birth records solely to audit the Harmony™ test, and understand that I would not be identified in reports of such audits. [Delete this sentence if you do NOT consent to releasing your result for audit purposes].

Signature  **PATIENT SIGNATURE** Date \_\_\_\_\_

### Collection appointment and payment

To finalise the order of your Harmony™ test, please visit [www.sonicgenetics.com.au/payment](http://www.sonicgenetics.com.au/payment) to complete your booking and payment. You will then receive an email and SMS with confirmation. Please make sure to bring this form and booking confirmation with you on the day. **Medicare benefits do not apply.**

## FOR THE COLLECTOR

I certify I established the identity of the patient named on this request, collected and immediately labelled the accompanying specimen(s) with the patient's name, DOB and date/time of collection.

Collector's name: \_\_\_\_\_

Signature  **COLLECTOR SIGNATURE** Date \_\_\_\_\_

Staff ID/Location code  
Collection type (stamp)

2 X NIPT tube

Date collected

/ /

Time collected

:

PAY CAT

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