



RESERVED
CGC Genetics

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GENETIC TEST REQUEST FORM PRENATAL

ORDERING PHYSICIAN

PHYSICIAN'S NAME*

DEPARTMENT

INSTITUTION*

PHONE

EMAIL*

CITY

COUNTRY

PATIENT INFORMATION

NAME*

DATE OF BIRTH* (dd/mm/yyyy)

MEDICAL RECORD NO.

GENDER*

female

BILING INFORMATION (if receipt is issued on patient's behalf):

VAT No.

ADDRESS

ZIP CODE

CITY

COUNTRY

SAMPLE*

BIOLOGICAL SAMPLE

☐ AMNIOTIC FLUID

☐ CHORIONIC VILLUS

☐ FETAL BLOOD

☐ MATERNAL BLOOD

☐ OTHER

COLLECTED AT

DATE AND TIME OF COLLECTION (dd/mm/yyyy)

REQUESTED TEST*

☐ Maternal cell contamination

(please include maternal blood sample [5 mL/EDTA]; validation of all prenatal molecular tests and female karyotype from CVS depends on performing this additional test)

☐ Karyotype

☐ QF-PCR for chromosomes 13, 18, 21, X and Y aneuploidies

☐ Array CGH

☐ Familial mutation (attach index genetic report)

Gene and mutation(s)

RefSeq

☐ Cystic fibrosis (CFTR common mutations)

☐ NGS panel for skeletal dysplasia

☐ NGS panel for Noonan syndrome and other genetically related syndromes

☐ NGS panel for craniosynostosis

☐ Other – for other genetic tests please visit www.cgngenetics.com

CLINICAL INFORMATION*

GESTATIONAL AGE AT DATE OF COLLECTION

_____ weeks, _____ days.

☐ Advanced maternal age (35+)

☐ High risk prenatal screening

☐ Increased NT

☐ Abnormal ultrasound

☐ Family history of

☐ Other

Please select at least one option

to be continued on the following page

I certify that (i) the patient (or legal representative) has agreed to have this testing performed, by signing the patient informed consent, (ii) the patient informed consent is in agreement with the legal requirements and that (iii) I am providing CGC Genetics all relevant medical information indispensable for the testing to be performed.

I certify that (i) I was informed about the benefits, risks and limitations of the test to be performed, (ii) I put all the questions that I consider relevant and understood the answers provided and (iii) that I understand that a normal result does not guarantee a normal baby. I give authorization to proceed with the requested genetic test and the use of the sample exclusively to this end.

☐ I agree

☐ I do not agree

The sample can also be used for scientific research purposes.

☐ I agree

☐ I do not agree

PHYSICIAN'S SIGNATURE _____
(mandatory)

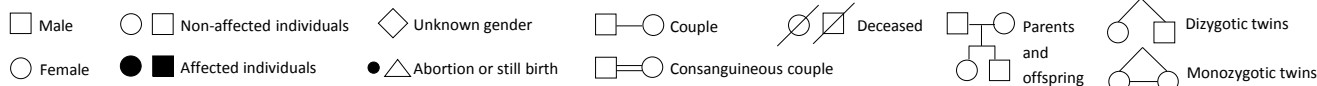
Date: ____/____/____

PATIENT'S SIGNATURE _____
(to be used in case no other informed consent is available)

Date: ____/____/____

CLINICAL INFORMATION (continuation)

FAMILY TREE



LEGAL NOTICE

Test Procedure. To perform the genetic test a fetal biological sample is required (obtained through an invasive procedure), such as amniotic fluid or chorionic villus. In specific tests and if maternal cell contamination exclusion has not been yet performed, it is also necessary a maternal blood sample (5mL/EDTA) together with the fetal sample. The sample(s) should then be sent to CGC Genetics, Rua de Sá da Bandeira, 706-1, 4000-432 Porto, Portugal. After the testing is performed, CGC Genetics will send the report with the results directly to your healthcare provider. In a twin gestation, the test provides results for each fetus if the samples are from individual fetuses.

Test Limitations. Consult with your healthcare professional to learn more about the test, including its limitations and risks, detailed description of the tested genetic changes and what the result could mean to you. Medical counselling is recommended before and after testing is performed. Prenatal genetic testing does not investigate the health condition of the pregnant woman. The following limitations may be associated with the prenatal genetic test: 1) The laboratory may not be able to process the test if the sample is in poor condition or due to other technical problems that prevent conclusive result. In these situations, and whenever possible, CGC Genetics will contact the patient or responsible healthcare provider to address a possible alternative. 2) In about 1% of cases a second fetal sample may be necessary due to insufficient material for a proper analysis or in a situation of discrepant results.

Privacy and test results. CGC Genetics is committed to ensure patient's data protection and confidentiality of all information originated during the whole process, according to the law. The result of your test will be directly sent to the requesting healthcare provider. Please request a copy of the test results directly to him/her. He/she is responsible for the interpretation and explanation of test results to you. CGC Genetics medical team is available to clarify your healthcare provider regarding any questions about your genetic test.

Patient rights. The patient can request the right of access, modification and cancellation of the data provided by letter addressed to CGC Genetics, Clinical Director to customercare@cgcgenetics.com.