

## REQUEST FORM

VeriRef Gold® Cod. 16203



Customer code: .....

## PATIENT INFORMATION

Required fields are marked with an asterisk (\*)

*Last name: .....		*Name: .....		*Birth date: dd/mm/yyyy	
Patient Id.: .....		*Weight (kg): .....		*Height (cm): .....	
Address: .....					
Country: .....		City: .....		ZIP code: .....	

## BLOOD SAMPLE

*Date of draw: dd/mm/yyyy	*Time of draw: .....
---------------------------	----------------------

## OBSTETRIC HISTORY

Number of previous deliveries: .....	Number previous miscarriages: .....	Number of abortions: .....
Date of last birth/abortion or miscarriage (month/year): mm/yyyy		History of pregnancies with chromosomal abnormalities or genetic diseases: ..... .....
Number of previous anomalous pregnancies: .....		

## REASON FOR REFERRAL

<input type="checkbox"/> First trimester biochemical screening	<input type="checkbox"/> Advanced maternal age	<input type="checkbox"/> Ultrasound findings suggestive of chromosomal abnormalities	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Early pregnancy loss <input type="checkbox"/> Recurrent pregnancy loss			

## CURRENT PREGNANCY

*Gestational age (weeks/days): .....		Method to determine gestational age: .....	
IVF PREGNANCY: <input type="checkbox"/> Yes <input type="checkbox"/> No	If IVF, own eggs: <input type="checkbox"/> Yes <input type="checkbox"/> No	If egg donation, indicate donator's age: ..... date of eggs' collection: dd/mm/yyyy	

## ULTRASOUND INFORMATION

Date of last ultrasound: dd/mm/aaaa	Gestational age by ultrasound (Weeks/days): .....
Fetal measurements: <input type="checkbox"/> Normal <input type="checkbox"/> Fetus smaller than gestational age <input type="checkbox"/> Fetus bigger than gestational age	
Morphological study: <input type="checkbox"/> Normal <input type="checkbox"/> Undone <input type="checkbox"/> with abnormalities (specify: .....) )	

## SCREENING PREVIO DE TRISOMÍA 21

<input type="checkbox"/> Yes   Test type: <input type="checkbox"/> TN + T1st trimester biochemical test <input type="checkbox"/> 2nd trimester biochemical test <input type="checkbox"/> 1st trimester biochemical test <input type="checkbox"/> Combined test: 1st and 2nd trimester <input type="checkbox"/> 2nd trimester ultrasound markers <input type="checkbox"/> Only TN 1st T (or other ultrasound markers)	<input type="checkbox"/> No Family history of genetic disease ..... Carrier of a genetic disease .....
---	--

## ORDERING HEALTH CARE PROFESSIONAL INFORMATION (Reporting Address)

*Last name: .....		*First name: .....		Email: .....	
Institution: .....		Department: .....		Phone: .....	Fax: .....
Address: .....		ZIP code: .....	City: .....	Country: .....	

\*I herewith confirm the correctness of the above given information.

 .....  
 Place, Date

 .....  
 Signature of ordering health care professional


# TEST INFORMATION AND CONSENT FORM

Required fields are marked with an asterisk (\*)

## Test limitations

1. Although the latest research data indicate that the test is highly accurate, with a detection rate of trisomy 21 close to 100% and a false positive rate of less than 1%, this test can not be considered diagnostic. It should only be considered as a very efficient screening test. Therefore, an abnormal result must always be confirmed by an invasive prenatal test, and a normal result can not exclude with total certainty an affected fetus due to these pathologies. This is due to several limitations of the current methodology.
2. This test has a number of limitations that prevent it from being used in cases of: mother with any of the changes to be analyzed, very early pregnancy (<10SG), fetal mosaicism of trisomies, presence of microduplications, chromosomal alteration in regions that were not analysed.
3. If the pregnant mother has received an allogeneic blood transfusion, transplant or stem cell therapy, there is a possibility of non-interpretable results due to the presence of exogenous DNA.
4. This test analyzes all microdeletions of the fetal genome >7Mb.

## Informed Consent

1. I fully understand the indication of the test, the objective, its characteristics and potential risks of this test. My doctor, Dr . \* ....., has answered all my questions about it.
2. I fully understand the limitations of this test, in particular that the detection rate of the changes studied is close but is NOT 100%. In cases of twin pregnancies, only trisomies of chromosomes 13, 18 and 21 and presence of the Y chromosome can be reported.
3. I confirm all the provided information about me is true and correct.
4. I understand that test result will be ready in about two weeks from when the lab receives the sample, but it could be ready in less time.
5. I was informed that it may be necessary to re-provide blood (<1% of cases).
6. I understand that the results are reference values and do not represent an element of clinical diagnosis. The results obtained should be considered in the context together with other clinical criteria, so it is recommended that these results be communicated in medical consultation.
7. I agree to provide information about my pregnancy, especially if my future baby is affected by some kind of genetic disease. I understand and authorize my doctor to contact me to know this information.
8. I give my consent for the use of clinical data by my laboratory for auditing, quality assurance and research purposes, provided that my person remains anonymous and not identifiable, and all the information I have provided is excluded from any publication. I can exercise my rights and revoke that consent at any time by contacting my laboratory.
9. About personal data: According to Spanish Law 41/2002, regulating Patient Autonomy, and Spanish Law 3/2018 on the Protection of Personal Data, the test applicant must have the written consent of the patient (and/or their legal representatives) to carry out this test and the treatment of their personal data. The information collected in this form will be incorporated into a confidential automated file under the terms established in Spanish Law 3/2018, with the purpose of carrying out the genetic study requested here. The patient, or their legal representatives, may at any time exercise their rights of access, rectification, deletion, limitation, opposition and portability by requesting it through his/her laboratory.

* Patient's name and last name:	* Patient's signature:	* Place and date:
* Healthcare professional prescriber name:	* Healthcare professional prescriber signature:	* Place and date: