GERMANO DE SOUSA
CENTRO DE MEDICINA LABORATORIAL

Please paste here the patient identification or provide the following data:

NAME

DATE OF BIRTH / /

REQUISITION OF PRENATAL GENETIC STUDIES

I. REQUESTING ENTITY

REQUESTING PHYSICIAN (READABLE)

EMAIL TELEPHONE

HOME ADDRESS

II. SAMPLE SENT AND COLLECTION DATA

1. SAMPLE

◯ AMNIOTIC FLUID ◯ FETAL BLOOD ◯ CHORIONIC VILLI (HARVEST: ◯ TRANSCERVICAL ◯ TRANSABDOMINAL)

◯ OTHER SPECIFY:

2. COLLECTION DATE / / BY DR.:

III. CLINICAL INFORMATION

1. GESTATIONAL AGE BY ULTRASOUND WEEKS BY THE DATE OF THE LAST MENSTRUATION: WEEKS

2. FETAL SEX ◯ MALE ◯ FEMALE ◯ NOT RATED

3. INDICATION FOR PRENATAL DEPARTMENT

◯ ADVANCED MATERNAL AGE

◯ CHILD WITH CHROMOSOMAL DISEASE. WHAT IS THE KARYOTYPE?

◯ POSITIVE BIOCHEMICAL SCREENING. PERFORMED BY IN / / CALCULATED RISK:

◯ ULTRASOUND SCREENING (INCREASED TN). PERFORMED BY: IN / / CALCULATED RISK:

◯ ULTRASOUND ABNORMALITIES. SPECIFY:

◯ PROGENITOR CARRYING CHROMOSOMAL DISEASE:

◯ OTHER, SPECIFY:

IV. INTENDED ANALYSIS (PLEASE MENTION ALL THE EXAMS REQUESTED IN THE TERM OF RESPONSIBILITY)

◯ KARYOTIPE

◯ RAPID SEARCH FOR ANEUPLOIDIES (CHROMOSOMES 13, 18, 21, X AND Y) BY QUANTITATIVE PCR

◯ FISH. SPECIFY:

◯ MOLECULAR STUDY. SPECIFY:

◯ ANOTHER STUDY. SPECIFY:

INFORMED CONSENT

I **CONSENT** to having the above genetic testing performed on which I was previously clarified in a clear and objective way on the application and limitations of the same.

I **AUTHORIZE** the collection of the biological sample required to perform the genetic test(s) indicated by the Germano de Sousa Laboratory Medical Center or, where necessary, by other laboratories designated by the same.

I **AUTHORIZE** that the data contained in this form are registered and processed only by duly authorized professionals, guaranteeing the protection and confidentiality according to the law in force.

I **GIVE MY CONSENT** for the result(s) to be sent to the prescribing physician.

I **HAVE BEEN INFORMED** of my right to revoke consent at any time without justification by sending an email.

SIGNATURE OF THE PATIENT OR THE LEGAL RESPONSIBLE (MINOR OR MAJOR INCAPABLE) OBLIGATORY

SIGNATURE OF THE DOCTOR OBLIGATORY

CONTACT FOR SUBMISSION OF RESULTS OBLIGATORY

IMPORTANT: Send the sample on the day of harvest. Do not send on Friday, not on the eve of holiday (consult central laboratory)

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CENTRO DE MEDICINA LABORATORIAL GERMANO DE SOUSA, SA · DIRECTOR: GERMANO DE SOUSA · Médico Patologista Clínico · LICENÇA DE FUNCIONAMENTO Nº 0117L/2009 · ENTIDADE REGULADORA DA SAÚDE Nº E117709

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