VCGS Leaders in Genetic Health

percept™ cell-free DNA prenatal test

Victorian Clinical Genetics Services
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The Royal Children's Hospital
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1. PATIENT INFORMATION

LAST NAME | GIVEN NAMES | DATE OF BIRTH (dd/mm/yyyy) | LABORATORY REF

ADDRESS | POSTCODE | PHONE (home) | MOBILE

2. CLINICAL INFORMATION

GESTATIONAL AGE: as of date:

EDD (dd/mm/yyyy):

MATERNAL WEIGHT (kg):

MATERNAL HEIGHT (cm):

3. TEST INDICATIONS

- ☐ percept™ AS PRIMARY SCREENING TEST
- ☐ ADVANCED MATERNAL AGE (≥37 YEARS)
- ☐ COMBINED FIRST TRIMESTER SCREEN RESULT
  T21: 1/_____ T18: 1/_____ T13: 1/_____
- ☐ ULTRASOUND ABNORMALITY: _____
- ☐ OTHER: _____

4. TEST OPTIONS

☐ **Singleton** pregnancy
Tests for chromosomes 21, 18, 13, X and Y

Fetal sex is always reported. Clinician to disclose to patient on request.

☐ **Twin** pregnancy
Tests for chromosomes 21, 18, 13 and presence or absence of Y.

Sex chromosome aneuploidy cannot be detected in twins. Fetal sex is always reported. Clinician to disclose to patient on request.

This test is validated for singleton and twin pregnancies of at least 10 weeks gestational age (by scan).

5. REQUESTING DOCTOR

NAME & PROVIDER #:

ADDRESS:

I verify that the patient and prescriber information in this form is complete and accurate to the best of my knowledge.

DOCTOR SIGNATURE AND DATE

_____ DATE: ____/____/____

6. PATIENT CONSENT

By signing this form, I request that VCGS perform the percept™ prenatal test. I have read the patient consent included on the back of this form. The risks and limitations of this test have been adequately explained to me.

PATIENT SIGNATURE AND DATE

_____ DATE: ____/____/____

COPY REPORTS TO:

PHLEBOTOMIST DETAILS:

COLLECTOR SIGNATURE SPECIMEN DATE & TIME (hrs)

7. PAYMENT DETAILS

Credit card details must be completed otherwise test results will not be available. If the payment fails, you will be contacted to verify and/or make payment by another method. If payment is not confirmed within 72 hours, the test will not be processed and a new sample will be required.

CARD TYPE ☐ VISA ☐ MASTERCARD AMOUNT TO BE DEBITED ☐ percept™ prenatal test $_____

NAME ON CARD _____ SIGNATURE _____

CARD NUMBER ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ EXPIRY DATE ☐☐☐☐