GENICA®
GENETIC AND MEDICO-DIAGNOSTIC LABORATORY

REQUEST FORM FOR PRENATAL DNA ANALYSIS OF MOST COMMON ANEUPLOIDY

❒ Trisomy 21 ❒ Trisomy 18 ❒ Trisomy 13 ❒ Sex aneuploidy

Additional analysis _____

Patient:[_____][_____][_____][_____]
/full name/ /Date of birth/

[_____][_____]
/Address/ /telephone/

Request physician: [_____][_____][_____][_____] [_____
/ full name / /Date/ /signature/

[_____] [_____]
/Healthcare unit/ / telephone /

**********:

❑ Age of the pregnant woman [_____]
❑ Risk for Down syndrome (Prenatal Screening) [_____]
❑ Risk for Eduards syndrome (Prenatal Screening): [_____]
❑ Risk for Patau syndrome (Prenatal Screening): [_____]
❑ Risk for Turner (Prenatal Screening): [_____]
❑ USG findings : _____
_____

❑ Pregnancy: _____
❑ Health children: _____
❑ Affected children _____
❑ Death before birth: _____
❑ Deceased children _____

❑ Abortions: _____
❑ Spontanous : _____
❑ Medical : _____
❑ Other: _____

❑ **Previouse pregnancy with chromosome aneuploidy**_____
_____
❑ **Previouse pregnancy with other birth anomaly**: _____
_____
❑ **Parents karyotype**: _____
_____
❑ **Sponatanous abortion**: _____
_____
❑ **Family history of chromosome disease** : _____
_____
_____

Samples from relatives **[***5 ml venous blood with* ***K_2 EDTA*** *(purple vacuteiner)***]***:*

N	*Full name*	*Date of birth*	*Inform consent:*	Family relationship
			❑ YES ❑ NO	
			❑ YES ❑ NO	

********** *SAMPLING INFORMATION* **********

Sampling: Date [_____] Time [_____] ❑ CHORION ❑ ACF ❑ Cordocentesis

Gestation week First Day of Latest Menstrual Period [_____] USG-based [_____] Number of Fetuses: _____

Comment:_____

Request physician [_____] Healthcare Unit [_____] Signature [_____]

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Sample:	*Amount*	*Blood in sample after centrifugation:*	*Sediment after centrifugation:*	*Comment*
❑ (AF)	_____	❑ YES ❑ NO	❑ YES ❑ NO	_____
❑ (CVS)	_____	❑ YES ❑ NO	❑ YES ❑ NO	_____
❑ (Tissue)	_____	❑ YES ❑ NO	❑ YES ❑ NO	_____
❑ Other	_____	❑ YES ❑ NO	❑ YES ❑ NO	_____

Sample received [_____] Date [_____] Signature [_____]

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