H9.2-F13 – v1, in voege 26/9/19

Request form

Non-invasive prenatal test (NIPT)

CENTER MEDICAL GENETICS UZ GHENT BELGIUM T +32 9 332 24 77 F +32 9 332 65 49

Please send the sample to the laboratory as soon as possible (within 24 hours after collection), this before 5 pm (on Friday before 2 pm). Keep the sample at room temperature. Send to:
UZ Gent, Medical Research Building - Center Medical Genetics, Entrance 34, Corneel Heymanslaan 10, 9000 Gent, Belgium.
More information about the collection, storage and transport of human samples and about the specific tests:
www.cmgg.be / www.uzgent.be/nl/zorgaanbod/mdspecialismen/CMGG.

IDENTIFICATION MOTHER

First and last name _____
Birth date _____
Address _____

_____

_____

National insurance number _____
Health insurance _____
Membership number _____ **CG1/CG2** _____ / _____

IDENTIFICATION PHYSICIAN

First and last name _____
RIZIV number _____
Address / department _____

_____

_____

Signature physician:

If patient is hospitalized

Approval number hospital _____
Hospital department _____
Hospitalization date _____

Copy result to: _____

_____

_____

BLOOD TEST (10ml in a blood tube suited for cfDNA analysis, e.g. PAXgene ccfDNA tube)

DATE BLOOD TEST: ____ / _____ / _____, Time _____

INFORMATION PREGNANCY

Ultrasound gestational age _____ weeks **Date ultrasound** _____ / _____ / _____
Expected birth date _____ / _____ / _____

Number of fetuses ☐ **Singleton**
☐ **Multiple pregnancy - number of fetuses:** _____ ☐ DC/DA ☐ MC/DA ☐ MC/MA
(DC/DA: dichorionic/ diamniotic; MC/DA: monochorionic/ diamniotic; MC/MA: monochorionic/ monoamniotic)

Oocyte donation ☐ no ☐ yes

PERSONAL HISTORY

Obstetric anamnesis _____
Previous pregnancy with a chromosomal abnormality? ☐ no ☐ yes name of the disorder _____
Familial genetic disease? Is the pregnant woman carrier of the genetic anomaly?
☐ no ☐ yes name of the disorder _____

INDICATION / CLINICAL INFORMATION

_____

_____

_____

Report gender of the baby? ☐ yes ☐ no

UZ GENT
UNIVERSITEIT GENT
Universitair Ziekenhuis Gent
C. Heymanslaan 10 | B 9000 Gent
www.uzgent.be

Informed consent

Non-invasive prenatal test (NIPT)

CENTER MEDICAL GENETICS, UZ GHENT BELGIUM T +32 9 332 24 77 F +32 9 332 65 49

I hereby certify that I was informed in an understandable manner regarding the non-invasive prenatal test (NIPT).

- I understand that NIPT is a non-invasive test that is performed on a blood sample from the mother, from the 12th week of pregnancy.
- I understand that this test is intended to detect trisomy 21 (Down syndrome), trisomy 13 (Patau syndrome) and trisomy 18 (Edwards syndrome) in the fetus.
- I understand that other tests are more suitable for detecting all other genetic disorders.
- I understand that this test is very accurate, but does not provide 100% certainty. If NIPT gives a normal result, the chance that my child will have trisomy 21, 13 or 18 is very small, but not completely excluded.
- I understand that the results of this test cannot be used to make a definitive diagnosis. An abnormal result should always be confirmed by means of an invasive diagnostic examination like amniocentesis.
- I understand that in about 1% of the cases no result can be obtained after the first blood test. In these cases, the analysis must be repeated on a new blood test.
- I understand that, because all chromosomes are analyzed during NIPT analysis, other chromosomal abnormalities can be detected in rare cases (for example, a trisomy of a chromosome other than 13, 18 or 21 in the fetus, or a clinically relevant chromosomal abnormality in the mother).
- I understand that this test can determine the gender of the fetus with high probability. I also understand that this test is not suitable for detecting abnormalities of the sex chromosomes.
- I understand that the NIPT result will be available after a maximum of 10 calendar days (calculated from the day of the blood sample).

I am sufficiently informed about the possibilities and limitations of the proposed genetic screening and have received a clear answer to all my questions. I agree that NIPT is performed for the prenatal detection of trisomy 21, 13 and 18.

Name parent _____

Date consultation _____ / _____ / _____

Signature parent _____

The undersigned has explained the information about the NIPT in a personal conversation and in an understandable language.

Name health caretaker _____

Date consultation _____ / _____ / _____

Signature health caretaker _____

Commissioned by responsible doctor _____