UZ LEUVEN

CENTRUM MENSELIJKE ERFELIJKHEID

8-24990-92-00

REQUEST FORM

NON-INVASIVE PRENATAL TESTING (NIPT)

tel. +32-16-345903 - fax +32-16-346060 - E-mail: stalenreceptieCME@uzleuven.be
Website: http://www.uzleuven.be/nl/centrum-menselijke-erfelijkheid/centrum-menselijke-erfelijkheid
http://www.uzleuven.be/en/nipt

09-2019

Nr. 3021

IDENTIFICATION MOTHER

UNIT: _____ ROOM/BED: _____ / _____

PATIENT IDENTIFICATION EAD-/HOS-nr. |_|_|_|_|_|_|_|_|

Last name: _____ First name: _____

Address: _____

Date of birth: |_|_|_|_|_|_| (d d m m y y) Gender: |_|

ADRESSOGRAM

INSURANCE COMPANY KG1/KG2: |_|_|_|_| / |_|_|_|_|

Insurance nr: |_|_|_|_| Family relation |_|

Stamnr.: _____

When paptient is hospitalized elsewhere: Name institution: _____

Identification nr.: _____ Department: _____

CLINICAL INFORMATION MOTHER

Gestational age: _____ **weeks**

Expected date of delivery: |_|_| |_|_| |_|_|_|_|

☐ Singleton pregnancy

Multiple pregnancy: ☐ DCDA ☐ MCDA ☐ MCMA ☐ vanishing twin

Weight before pregnancy: |_|_|_| kg

Heigth: |_|,|_|_| m

INFORMED CONSENT

TO BE COMPLETED ON THE BACK PAGE

BLOOD SAMPLING

STRICT GUIDELINES

A blood sample of the mother (cfDNA tube [Streck/Roche]) should be delivered to the laboratory within 72 hours.

Maternal blood:

3470 ☐ 1 full STRECK tube (camouflage pattern)

3470 ☐ 1 full cfDNA tube (white cap, Roche)

Date of blood sampling: |_|_| |_|_| |_|_|_|_|

Time of blood sampling: |_|_| h |_|_| min

INDICATION

☐ Maternal age:

Specify: _____ years of age

☐ Family history:

Specify: _____

in _____

☐ Personal request of the patient

☐ Other relevant clinical information:

Specify: _____

_____

_____

CLINICIANS IN COPY

Gynaecologist: _____

Family doctor: _____

DATE OF REQUEST: |_|_| |_|_| |_|_|_|_|

REFERRING Dr.: _____

I.D. nr.: N° INAMI: |_| |_|_|_|_|_| |_|_| |_|_|_|_|

Signature

FETUS (FOR INTERNAL USE)

PATIENT IDENTIFICATION EAD-/HOS-nr. |_|_|_|_|_|_|_|_|

Last name: _____ First name: _____

Address: _____

Date of birth: |_|_|_|_|_|_| (d d m m y y) Gender: |_|

ADRESSOGRAM

INSURANCE COMPANY KG1/KG2: |_|_|_|_| / |_|_|_|_|

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Art. 613021

09-2019

CONSENT FORM
NON-INVASIVE PRENATAL TESTING (NIPT)

UZ LEUVEN | CENTRUM MENSELIJKE ERFELIJKHEID

INFORMED CONSENT OF THE MOTHER

1. I have been informed about the possibilities and limitations of this test, as described in the information brochure. I have had the opportunity to ask my doctor for additional information.

2. I understand that NIPT is designed to detect trisomy 21, 18 and 13 as from 12 weeks of gestation. Other more appropriate testing may be required when there is an increased risk for certain other genetic disorders.

3. I have been informed that the NIPT is very accurate, but not 100%. In case of a normal result, the probability that the baby would still have trisomy 21, 18 or 13 is very low, but cannot be completely excluded. An abnormal result should always be confirmed by invasive prenatal testing (preferably amniocentesis).

4. I have been informed that the result will be available within a maximum of 7 calendar days from the receipt of the blood sample in our laboratory. I can consult my results in my online medical file through **www.mynexuzhealth.be.**

5. I understand that in rare cases, the NIPT is inconclusive or fails. In this case, the NIPT can be repeated once on a second blood sample (at no additional cost).

6. Using NIPT, all chromosomes are analyzed. Therefore, in rare cases, NIPT can also detect other chromosomal abnormalities, such as a trisomy of another chromosome or a chromosome abnormality important for my own health or that of my baby. The Centre for Human Genetics or my gynaecologist will contact me should this be the case.

7. I understand that NIPT is reimbursed in Belgium. In that case, my personal cost for the laboratory test is **€ 8,68.** In case of an increased allowance, the NIPT is free of charge. When I'm not a member of a Belgian service for public health insurance, I will be charged € 263,25.

8. I agree that the residual material and genomic data after NIPT can be used anonymously for validation, internal quality control or research purposes (for example optimization of NIPT and new developments).

☐ I confirm that during this pregnancy a combined test or NIPT has not already been performed and reimbursed by the public health insurance.

☐ I understand the above information and I agree that NIPT may be performed.

MOTHER	CLINICIAN
Name:_____	Name:_____
Date: __/__/____	Date: __/__/____
Mobile phone nr.: + __ ____ _____	Signature:
E-mail: _____	
@ _____	
Signature:	

please complete in capital letters