FIRST TRIMESTER SCREEN REQUEST FORM

AUSTRALIAN Clinicallabs

ACC STAMP

1300 134 111

antenatal.clinicallabs.com.au

FIRST TRIMESTER SCREEN

PATIENT INFORMATION

Patient Surname

Patient Given Name

Date of Birth (DOB) / / Please format DD / MM / YY

Address

City

State Post Code

Phone

Mobile

Medicare IRN Ref

CLINIC INFORMATION

Referring Clinician Name

Address

City

State Post Code

Phone Provider No.

Copy To (please include ultrasound clinic details)

Clinic Name

Address

Phone

CLINICAL INFORMATION - MANDATORY

Gestational Age, choose A *OR* B:

A. _____ weeks ____ days Measured on: _____/_____/_____ (DD / MM / YY)

B. ☐ LMP ☐ EDD ☐ IVF Date: _____/_____/_____ (DD / MM / YY)

Clinical Due Date: _____/_____/_____ (DD / MM / YY)

Number of Fetuses: 1 2

Weight _____ (kg) Height _____ (cm)

Conception Information:

Natural

IVF (Patient Egg) | Age at egg retrieval: _____Years

IVF (Donor Egg) | Age at egg retrieval: _____Years

DOB of egg donor: _____/_____/_____ (DD / MM / YY)

Date of egg transfer: _____/_____/_____ (DD / MM / YY)

Is this a recollect? Yes No

History suggestive of high risk chromosomal abnormalities? Yes No

Previous history of ☐ T21 (Down) ☐ T18 (Edwards) ☐ T13 (Patau)

Family history of ☐ T21 (Down) ☐ T18 (Edwards)

FIRST TRIMESTER SCREENING (FTS) - MANDATORY 9 - 13.6 WEEKS

 x1

☐ Maternal Serum Screen (PAPPA + BhCG)

☐ Placental Growth Factor (PlGF) (Pre-Eclampsia Predictor) **extra charge*

Current History:

Smoker Yes No

Diabetes (NIDDM only) Yes No

Ethnic Group:

☐ Caucasian ☐ Aboriginal ☐ Afro-Caribbean

☐ Asian ☐ Other

CLINICIAN SIGNATURE

I attest that my patient has been fully informed about details, capabilities, and limitations of the test(s). The patient has given full consent for this test.

Clinician Signature X

Date / / Please format DD / MM / YY

BILLING INFORMATION

Please tick one:

☐ Commercial Client (Biller Code _____)

☐ Pay over phone (call centre) Receipt # _____

Patient relationship to person paying for test: ☐ Self ☐ Spouse ☐ Other

Payment is required following sample collection at one of our collection centres. Please call 1300 369 762 to make your payment over the phone and select option 3. Lines are open Mon-Fri 9am-5pm (AEST). For patients in WA, please call (08) 9442 7646 (lines are open Mon-Fri 8am-4pm AWST). Once payment is received your sample will be processed and your results will be sent to your referring doctor 3-4 business days after the ultrasound report is received by the lab.

PATIENT INFORMED CONSENT

My signature on this form indicates that I understand the informed consent and give permission to Australian Clinical Labs to perform the laboratory Antenatal Screening tests selected. I have had the opportunity to ask questions and discuss the capabilities, limitations, and possible risks of the test(s) with my healthcare provider or someone my healthcare provider has designated. I have been informed that 1-2% of tests do not yield a result due to biological factors; and that a second collection maybe required. I know that if I wish, I may obtain professional genetic counseling before signing this consent.

Patient Signature X

Date / / Please format DD / MM / YY

COLLECTION INFORMATION

Person collecting specimen to complete:

I certify I established the identity of the patient named on this request, collected and immediately labeled the accompanying specimen(s) with the patient's details.

Date of Collection: ____/____/____ (DD / MM / YY) Time of Collection: _____ Collector Name _____ (Please print) Collector Signature X _____