

## TEST REQUISITION FORM

### NextGen NON INVASIVE PRENATAL SCREENING (NIPS)

**PATIENT INFORMATION**

Name of Patient: .....

Address: .....

Date of Birth: .....

Email Id: .....

Contact No: .....

Authorised Id No: .....

Aadhar/Pan/Voters Id/ Passport/Driving License  
Any one of the document\*

Attached Copy of the Id: .....

**CLINICIAN INFORMATION**

Clinician Name: .....

Hospital/Clinic Name: .....

Address: .....

.....

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Email Id: .....

Contact No: .....

Sample Collection Date and Time 

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	T	I	M	E
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 Barcode:

**CLINICAL INFORMATION:**

1 Gestation Age (on Collection Date):   Wks  Days      2 LMP: ...../...../.....

3 EDD: ...../...../.....      4 Maternal Weight:    kgs      5 Maternal Height:     Ft. inch  cm

6 Maternal BMI (optional):

**7 PREGNANCY HISTORY:**

A Gravida  Parity

B Spontaneous Abortions: Yes  No  If Yes Please Specify: .....

C Termination of Pregnancy: Yes  No  If Yes Please Specify: .....

D Molar/Ectopic Pregnancy: Yes  No  If Yes Please Specify: .....

E SINGLETON:  TWINS:  MCMA:  MCDA:  DCDA:

F Natural Conception:  IVF:  Donor Egg:  Self:  Surrogate:  Maternal Age At Egg Retrieval:

**8 CLINICAL INDICATIONS:**

A Consanguinity: Yes  No

B History of Chromosome Abnormalities in Previous Pregnancies/child: .....

C Family History of Genetic Disease: .....

D Ultrasound Abnormalities: (Attach latest USG report\*): .....

E Nuchal Translucency: NT Measurements: NT (mm): ..... CRL (mm): .....

F Dual Marker/Quadruple Marker Risk Score (Attach report\*): .....

G Quadruple Marker Risk Score (Optional/Mandatory - Depending on gestation) .....

H Advanced Maternal Age: .....

I Others: .....

**Note:** 1) \* are mandatory requirements.  
2) Blood sample will be collected at PCPNDT registered centers only.

## DECLARATION BY EXPECTANT MOTHER

I, Ms./ Mrs. \_\_\_\_\_

residing at \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Contact number \_\_\_\_\_

declare that I wish to undergo the NextGen NIPS (Non-invasive prenatal screening) test.

I do not intend to know the sex of my fetus. I have been explained in a language that I understand that sex determination of the baby during pregnancy is illegal and banned in India and hence sex of the fetus will not be detected nor disclosed to anybody while performing this test.

Signature of Expectant Mother

Date:

## PATIENT INFORMED CONSENT STATEMENT

I have been provided the information regarding the test, the intended purpose, potential risks and limitations of the NextGen NIPS test. I am aware that the test is intended for detection of Trisomy 21, Trisomy 18, Trisomy 13 and sex chromosomal abnormalities and does not detect abnormalities of other untested chromosomes, microdeletions, mosaicism, balanced translocation, partial chromosome aneuploidy, polyploidy, birth defects or genetic disorders. I also understand that this is a screening test which provides the risk or probability of fetus having the chromosomal abnormalities, but doesn't confirm the abnormality.

I understand that the NextGen NIPS is not a diagnostic but a screening test and hence the results should be considered, interpreted and correlated in conjunction with clinical criteria, ultrasound findings and evaluation of supportive data and test results. I am also aware that the NextGen NIPS test will be performed at MHL while the bioinformatics analysis will be done by partner lab. The results of the test will be provided in 10-12 days. In case of a positive result, the findings should be confirmed by alternate invasive procedures to arrive at a final diagnostic determination.

Although the test is highly accurate, there is a small possibility that the test may provide false positive or false negative results. This could be due to technical and biological limitations like Confined placental mosaicism (CPM), maternal constitutional or somatic chromosomal abnormalities, residual cfDNA from a vanished twin or other rare molecular events.

I understand that there is 3-5 % chance of test failures due to low fetal fraction obtained from the specimen, haemolysis or technical failures, in which case a repeat sample may be requested at no extra cost.

I understand that sex determination will not be provided by this test.

I have provided reliable personal details and relevant information regarding my pregnancy. I understand that the test results will be communicated to me by my clinician and decisions taken thereafter.

I provide my consent for the use of the clinical information for the purpose of audit, quality assurance and research with complete confidentiality of my pregnancy and personal information.

I hereby indemnify Metropolis Healthcare Ltd and its staff in full against all consequences, liabilities of any kind whatsoever directly arising from unforeseen circumstances concerning the test/s or results of the test/s.

Name:

Signature:

Date: Place:

## CLINICIAN'S STATEMENT

I attest that this patient has been informed about the details, benefits and limitations of the NIPS test and has given consent for this test.

\* Date:

\* Clinician Name:

\* Clinician's Signature:

\* Seal:

**Note:** \* are mandatory requirements.