REQUEST FORM: PRENATAL GENETIC TESTING

SAMPLE INFORMATION	LNS BARCODE LABEL
Identification of sampler *(Or sampler label)*	LNS LABEL

LNS LUXEMBOURG

LABORATOIRE NATIONAL DE SANTE
NATIONAL CENTER OF GENETICS

1, rue Louis Rech
L-3555 Dudelange
Tel. (+352) 28 100 - 549
Fax. (+352) 28 100 - 542
avis-prescription-genetique@lns.etat.lu
Form available at www.lns.lu

PHYSICIAN REQUESTING THE TEST

Surname and first name of the doctor requesting the test

Address and country

Telephone / direct line

Fax

Date of request

Signature / Stamp

Copies to [Please note that results are returned only to the prescriber of the test, who is the only one authorized to give them to patients.]

PATIENT

Birth name

First name

Married name

Sex

Date of birth

Matricule

Address and country

Patient covered by the CNS ☐ **YES** ☐ **NO***

*If not covered by the CNS, the patient will receive an invoice from the laboratory, which they may pass on to their insurance company, where applicable.

SAMPLE

Date and time of sampling: ..... Time of sampling: .....

Time of sending: ..... *(Please join blood sample on EDTA tube)*

☐ Amniotic liquid *(minimal quantity : 20 ml)*

☐ Chorionic villi *(minimal quantity : 20 mg)*

☐ Blood form fetus or umbilical cord *(minimal quantity : 2 ml)*

☐ Placenta/ Miscarriage

Appearance of the sample : .....

Quantity of the sample : .....

☐ Other: .....

Parental samples
EDTA Tube 5 mL

NOTE D'INFORMATION

- Please see the specific request form for NON-INVASIVE PRENATAL TEST (NIPT) and for Fœtal RhD. Available at www.lns.lu/XXX
- Please fill out and the attached informed consent form for genetic testing, both the patient and the prescriber must sign the consent form.
- For any request for molecular genetic testing not listed below please contact the laboratory beforehand at: avis-prescription-genetique@lns.etat.lu. A pre-test genetic consultation might be indicated.
- Clinical information are mandatory, please specify the reason for testing.

INDICATION

Weeks of gestation SA: ..... Pregnancy: G..... P .....

☐ Abnormalities found on ultrasound scan: *please specify below and provide the report*

☐ Positive NIPT: *please specify below and provide the report*

☐ History of fetal aneuploidy or familial chromosomal abnormality: *please specify below and provide the report*

☐ Prenatal diagnostic of a specific genetic disease : *please specify below and provide the report*

☐ Early miscarriage

☐ Other: .....

CLINICAL AND/OR GEOGRAPHIC AND/OR GENEALOGIC INFORMATIONS

REQUESTED ANALYSIS

☐ Karyotype

☐ Targeted FISH: *(specify the locus)* .....

☐ QF-PCR : Rapid Aneuploidy Detection: 13/18/21- X/Y *(Blood samples on EDTA tube for the mother is mandatory)*

☐ AFP Dosage (Done by Biologie Clinique Department)

☐ CGH-array *(Blood samples on EDTA tube for both parents are recommanded)*

☐ Targeted analysis: ☐ CFTR ☐ Other : .....

Specify the identity of the Father :

Birth name

First Name

Matricule

RESERVED FOR RECEPTION CENTRALISEE (LNS)

MOLGEN-PR1-FOR-03100 ; v1

The LNS processes the data collected for the performance of analyzes and the transmission of results. To find out more about the management of personal data and to exercise your rights, please refer to the data protection policy on the LNS website at the following address: https://lns.lu/donnees-personnelles/

CONSENT FORM

By signing below, I consent to the genetic testing as indicated on the test request form in order to determine the genetic cause of the above-mentioned clinical condition.
I hereby confirm, that the requesting physician (signed below) has informed me in detail about the medical necessity, potential benefits and limitations of the planned genetic testing. In addition, possible consequences from the communication of the test result (e.g. psychological burden) were discussed.

With your consent, **unused sample material** will be stored. Please decide if and how unused sample material may be used. I consent to the use of this material - for verifying the obtained results, laboratory quality assurance and future diagnostic investigations. - for the purposes of academic teaching and scientific research.	 ☐ Yes ☐ No ☐ Yes ☐ No
I consent being informed[1] of **secondary/additional findings[2]** if these have direct medical implications (e.g. possible prophylactic measures or therapeutic consequences) or may constitute a significant genetic risk for me or my family members. [1] According to current scientific understanding and based on the present recommendations of the American College of Medical Genetics and Genomics (ACMG). [2] Variants that may be obtained incidentally during the course of genetic testing and are associated with a condition other than the one for which testing was originally indicated.	☐ Yes ☐ No
If necessary, I consent that my sample material, my personal data and the test request is **forwarded** to a specialized cooperating laboratory or institute in order to investigate the above-stated condition in question.	☐ Yes ☐ No
I consent that data and test results collected in the context of the condition in question may be used in de-identified (pseudonymized) form for **scientific research**[1] and published in anonymized form in medical journals. [1] e.g. to improve the understanding of the molecular pathogenesis and develop new diagnostic or treatment possibilities)	☐ Yes ☐ No

I am aware that my consent applies to me and/or to my minor child (ren) and I may withdraw this consent at any time, verbally or in writing, without giving reasons.

Place and date:_____

Signature of requesting physician _____

Signature of patient or legal representative(s) _____