

PRENATAL REFERRAL FORM

Patient Information:

Surname: _____
 First name: _____
 NHI: _____
 DOB: _____ Age: _____
 Sex: _____

Referring Clinician information:

Referring Dr: _____
 Phone Number: _____
 Address: _____

 Signature: _____ Date: _____

Referral Information:

Gestational Age: By date _____ By scan _____
 Obstetric History: P _____ G _____
 Previous Amniocentesis? Y / N
 If Yes, result? _____

Copy to Dr: _____
 Address: _____

Test Requested:

- Cytogenetics
 Aneuscreen FISH
 Other (Please state) _____

Specimen Information:

Type:
 POC Amnio CV
 Date and time collected: _____
 Procedure performed by: _____

Do parents wish to know sex?

Requirements: Tissue or fluid

- Please ensure the following:
- Contact IGENZ to arrange pick up 09 307 3981
 - 2 forms of ID on container, identical to referral form

Supplementary Information: (If required)

Delivery Address:

IGENZ Ltd,
 Level 2 Quay Park Health,
 68-70 Beach Rd,
 Auckland CBD
 Phone 09 307 3981

Lab use only:

Date and Time received _____ By: _____
 Specimen Type _____ Volume _____
 Appearance _____