Prenatal Referral Form

Contact IGENZ to arrange transportation of sample on 09 307 3981

Patient Information	
Surname:	First name:
NHI:	Sex:
DOB:	Date and time collected:

Clinical Information (please tick):
Specimen Type: ☐ Amnio ☐ CV ☐ POC
Gestational Age:
Obstetric History: P G
Do parents wish to know sex? ☐ Y ☐ N

Reporting Information	
Referring Dr:	Email:
Address:	
Signature/Date:	
Copy to:	Email:
Address:	

Test Requested (please tick)
☐ Aneuscreen FISH
☐ Cytogenetics (Conventional G-banded metaphase analysis)
☐ Other FISH probes (please specify)

Sample Requirements
All samples MUST be labelled with 2 unique identifiers identical to the referral form
Samples should be transported at ambient temperature

Contact information: IGENZ LTD, Level 2, Quay Park Health, 68–70 Beach Road, Auckland 1010, PO Box 106542, Auckland 1143 New Zealand T +64 9 307 3981 F +64 9 307 3983 info@igenz.co.nz www.igenz.co.nz