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

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