NHS TEST DIRECTORY R445 REFERRAL

PLEASE SEND THIS TOP COPY WITH THE SAMPLE

For Laboratory use only

Place the FORM barcode label here

TAP5339B/08-02-24/V5

Woman's Information

First Name

Last Name

Date of Birth (DD/MM/YYYY)

Address

City

Postcode

NHS Number Hospital Number

Ethnicity

- ☐ **A** White British
- ☐ **B** Irish
- ☐ **C** Any other White background
- ☐ **D** White and Black Caribbean
- ☐ **E** White and Black African
- ☐ **F** White and Asian
- ☐ **G** Any other mixed background
- ☐ **H** Indian
- ☐ **J** Pakistani
- ☐ **K** Bangladeshi
- ☐ **L** Any other Asian background
- ☐ **M** Caribbean
- ☐ **N** African
- ☐ **P** Any other Black background
- ☐ **R** Chinese
- ☐ **S** Any other ethnic group
- ☐ **Z** Not stated
- ☐ **99** Not known

Weight (kg) at time of NIPT sample collection

Confirmation of eligibility

Please confirm the following have been considered and excluded (tick Yes if excluded):

- maternal cancer (unless in remission) ☐ No ☐ Yes
- blood transfusion in the last 4 months (whole blood or plasma) ☐ No ☐ Yes
- bone marrow or organ transplant recipient ☐ No ☐ Yes
- vanished twin pregnancy (an empty second pregnancy sac or a second pregnancy sac containing a non-viable fetus) ☐ No ☐ Yes
- maternal T21 ☐ No ☐ Yes
- balanced translocation or mosaicism of T21, T18 or T13 ☐ No ☐ Yes
- immunotherapy in the current pregnancy, excluding IVIg treatment ☐ No ☐ Yes
- stem cell therapy ☐ No ☐ Yes

Further clinical details that require discussion with the NIPT laboratory prior to obtaining sample:

Does the following apply to the woman?

- any known chromosomal or genetic condition other than T21, T18 or T13 in pregnant woman ☐ No ☐ Yes

If Yes, please contact the laboratory to discuss prior to obtaining the sample.

Clinic Information

Hospital Name and 5 Digit ODS Code

Ordering Clinician

Address

City

Postcode

Phone

NHS Email

Referring Clinician

Screening options requested

☐ T21, T18, T13 ☐ T21 only ☐ T18 and T13 only

Essential clinical information*

Gestational age at NIPT sampling date by ultrasound

weeks ______ days ______

EDD by ultrasound (DD/MM/YYYY)

Number of Fetuses* ☐ 1 ☐ 2

IVF Pregnancy?* ☐ No ☐ Yes

Chorionicity for twin pregnancy

☐ Monochorionic ☐ Dichorionic ☐ Unknown

Eligible for R445 Common Aneuploidy Testing – NIPT

Previous trisomy

☐ T21 ☐ T18 ☐ T13

IMPORTANT BLOOD DRAW INFORMATION

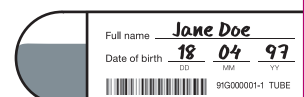
Sample requirements

- Minimum of 6.5ml of maternal blood in cell stabilising tube.
- The tube should be gently inverted 10 times after blood draw.
- Do not refrigerate.
- Send to NIPT laboratory as soon as possible following sample collection.
- Inform the NIPT laboratory that a sample is on its way.
- Laboratory to confirm receipt of sample.

Complete A & B: (DD/MM/YYYY)

A. Blood collected on: ______ by: ______

B. Write the woman's full name and date of birth on tube barcode label. Name, barcode and date of birth must match the Request Form. Place label lengthwise on the cfDNA tube as shown in the example.



HEALTH SERVICES LABORATORIES

Health Services Laboratories, NIPT SRA Level 6
The Halo Building, 1 Mabledon Place, London WC1H 9AX
T +44(0)20 7307 7409 | E tdlgenetics@tdlpathology.com
www.hslpathology.com

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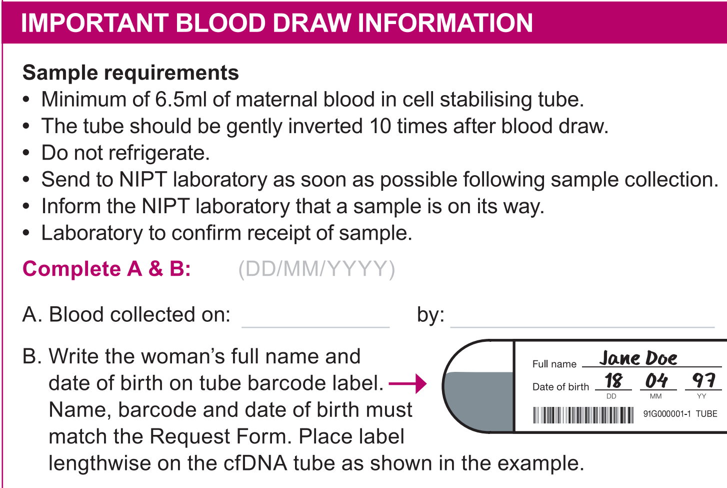

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