Sonic Genetics
Clinpath Adelaide Pathology

harmony™ PRENATAL TEST
performed in Australia

Laboratory number

LABORATORY COPY

Non-Invasive Prenatal Test | Request Form

FOR THE DOCTOR

This test should be requested by the doctor responsible for managing a woman's decision-making regarding Non-Invasive Prenatal Testing.

Patient details

First name _____ Surname _____

Date of birth ___/___/___ Gender **Female – Pregnant**

Address _____

_____

_____

Phone (mobile) _____

Test/s requested

SINGLETON

☐ Harmony™ Prenatal Test T21, T18, T13

☐ Monosomy X

☐ Fetal gender

☐ Sex chromosomes aneuploidy panel

TWIN

☐ Harmony™ Prenatal Test T21, T18, T13

☐ Fetal gender (detects presence of one or two male twins)

Is this a ☐ **RECOLLECTION?** Previous Lab ID _____

Clinical information REQUIRED

ALL fields must be completed for testing to proceed.

Note If any of the clinical information changes, the lab must be notified as the data captured below is included in the test algorithm.

GESTATIONAL AGE

Either Weeks ____ Days ____ as at ___/___/___ (date)

or ☐ LMP ☐ EDC ☐ IVF ___/___/___ (date)

CONCEPTION DETAILS

☐ Natural ☐ IVF (Patient egg) | Maternal age at egg retrieval ____ yrs

☐ IVF (Donor egg) | Maternal age at egg retrieval ____ yrs

MATERNAL INFORMATION

Maternal weight (kg) _____ Maternal height (cm) _____

Harmony™ Prenatal Test is not validated for 3 or more fetuses, or in the presence of a demised fetus. The Harmony™ Prenatal Test examines for certain aneuploidies in viable singleton and twin pregnancies by natural or IVF conception after 10 weeks' gestation. Specific exclusions are detailed at www.sonicgenetics.com.au. Please note that the requested clinical information is essential for test accuracy.

Requesting doctor

Name _____

Address _____

_____

_____

Phone _____ Provider No _____

I confirm that this patient has been counselled about the purpose, scope and limitations of the test and has given consent.

Signature ✕ CLINICIAN SIGNATURE Date

Copy reports to

Name _____

Address _____

_____

FOR THE PATIENT – Patient consent

I consent to the Harmony™ Prenatal Test being performed and confirm that I have been informed about the purpose, scope, and limitations of the test by my doctor, patient literature and/or the Sonic Genetics website. I understand that the test is a screen for selected abnormalities of chromosomes 21, 18 and 13; that the test can also screen for less serious selected abnormalities of the sex chromosomes, and identify fetal gender; that the result should be reviewed by my doctor in the light of other findings; that a 'high-risk' result should be confirmed by fetal karyotype; that a second collection may be required; and that 1-2% of tests do not yield a result due to biological factors (with prepaid tests for chromosomes 21, 18, and 13 being refunded). I have had the opportunity to ask questions and understand that I can request further information or genetic counselling.

I consent to my identified result being used with Government birth records solely to audit the Harmony™ test, and understand that I would not be identified in reports of such audits. [Delete this sentence if you do NOT consent to releasing your result for audit purposes].

Signature ✕ PATIENT SIGNATURE Date

Collection appointment and payment

To finalise the order of your Harmony™ test, please visit **www.sonicgenetics.com.au/payment** to complete your booking and payment. You will then receive an email and SMS with confirmation. Please make sure to bring this form and booking confirmation with you on the day. **Medicare benefits do not apply.**

FOR THE COLLECTOR

I certify I established the identity of the patient named on this request, collected and immediately labelled the accompanying specimen(s) with the patient's name, DOB and date/time of collection.

Collector's name: _____

Signature ✕ COLLECTOR SIGNATURE Date

Staff ID/Location code Collection type (stamp)	☐ 2 X NIPT tube Date collected ___/___/___ Time collected ___:___	PAY CAT SGU