GOVERNMENT OF WESTERN AUSTRALIA

PathWest LABORATORY MEDICINE WA

Diagnostic Genomics
2nd Floor, PP Block
Hospital Avenue, Nedlands
Western Australia 6009
ABN 83 469 340 804

ENQUIRIES
(08) 6383 4234

FETAL DIAGNOSTIC GENOMICS REQUEST

LAB No. (PathWest)

PATIENT Last Name | Given Name (including middle initial) | Date of Birth | Sex

PATIENT Address | Unit no. | Your Reference

use patient label if available

TEST REQUESTED ***Please write below the tests required.***

Consultant:

Requesting Doctor:
Surname, Initials, Provider Number, Address, Phone and Fax Numbers.
Fax number is required to receive a copy of the report.

Phone No: _____

Fax No: _____

Location: _____

Patients referred by GPs and private patients must complete the Medicare Assignment details below.

To comply with Privacy Act requirements, these patients must also provide consent for genomic test results to be entered into the iCM (see below).

☐ DO NOT SEND REPORTS TO MY HEALTH RECORD

Results to HDWA Clinical Information System (iCM)
See CIS informed Consent Information Sheet.

Patient Signature
I consent for my results to be stored in the iCM.

✗ _____

SAMPLE TYPE ***(Please circle)***

Amniotic fluid (***20 mls*** *recommended)*	CVS	Cord blood *(EDTA)*

Comments (if applicable): _____

Doctor's Signature / Request Date

✗ _____ ___/___/___

Patient Status at Time of Service or When Specimens Collected:

	YES	NO
1. A private patient in a private hospital or approved day hospital facility	☐	☐
2. A private patient in a recognised hospital	☐	☐
3. A public patient in a recognised hospital	☐	☐
4. An outpatient of a recognised hospital	☐	☐

COLLECTOR'S SIGNATURE

I certify that the fetal specimen and accompanying maternal blood sample were obtained from the mother named on this form. I established her identity by direct inquiry and/ or inspection of the wrist band. I labeled the samples immediately after collection.
The mother has verified that her name and date of birth on all specimen containers are correct.

✗ _____ Date: ____ / ____ / ____ Time: _____

Copy Reports to:

Fax No: _____
(required to receive report copy)

Bill to:

Medicare Number:

_____

Medicare Assignment
(Section 20A Health Insurance Act 1973)
I offer to assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner.
Patient's Signature / Date

✗ _____ ___/___/___

FETAL PATHOLOGY TISSUES

Tissue(s) (***please circle***)				Tissue state (***circle***)
Muscle	*Skin*	*Brain*	*Other (details)*	*Fresh*
Tendon	*Liver*	*Umbilical*		*Macerated (moderate)*
Cartilage	*Lung*	*Placental, incl, PoC*		*Macerated (severe)*

CLINICAL NOTES ***If structural anomalies, please complete reverse side.***

Gestation: ___ weeks

Your doctor has recommended that you use PathWest. You are free to choose your own pathology provider. However, if your doctor has specified a particular pathologist on clinical grounds a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your doctor.

Specified APP: Yes / No

APP Name_____

Practitioner's Use Only
(Reason patient cannot sign)

RCPA The Royal College of Pathologists of Australasia

NATA WORLD RECOGNISED ACCREDITATION

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MATERNAL SAMPLE

LAB No. (PathWest)

PATIENT Last Name | Given Name (including middle initial) | Date of Birth | Sex

PATIENT Address | Unit no. | Your Reference

use patient label if available

Requesting Doctor *(Surname, Initials, Provider Number, Address)*

TESTS REQUESTED Maternal blood - **EDTA** anticoagulant (**5 mls** recommended)
e.g. maternal cell contamination studies, verification of fetal sample identity, etc.

Doctor's signature / Request Date

✗ _____ ___/___/___

RCPA The Royal College of Pathologists of Australasia

NATA WORLD RECOGNISED ACCREDITATION

FETAL ANOMALY DETAILS

Anomaly details increasingly aid the task of determining the clinical significance of small chromosomal gains and losses.

Please complete the checklist below and insert completed form in the sample package.

LAB No. (PathWest)

PATIENT Last Name ..... Given Name .....

ULTRASOUND - CLINICIAN Name .....

Fetus / Amniotic Fluid
- ☐ Increased nuchal translucency
- ☐ Cystic hygroma
- ☐ Hydrops
- ☐ Oligohydramnios
- ☐ Polyhydramnios
- ☐ Intrauterine growth restriction
- ☐ Other: _____

Cardiac
- ☐ Ventricular septal defect
- ☐ Tetralogy of Fallot
- ☐ AV canal defect
- ☐ Transposition great vessels
- ☐ Truncus arteriosus
- ☐ Double outlet right ventricle
- ☐ Coarctation of the aorta
- ☐ Aortic atresia
- ☐ Pulmonary valve atresia
- ☐ Hypoplastic left heart
- ☐ Hypoplastic right heart
- ☐ Dextrocardia / situs inversus
- ☐ Ebstein anomaly
- ☐ Other:

Neurological
- ☐ Holoprosencephaly
- ☐ Neural tube defect
- ☐ Ventriculomegaly
- ☐ Hydrocephaly
- ☐ Cerebellar hypoplasia
- ☐ Dandy-Walker anomaly
- ☐ Agenesis corpus callosum
- ☐ Other: _____

Craniofacial
- ☐ Cleft lip / palate
- ☐ Choanal atresia
- ☐ Hypertelorism
- ☐ Hypotelorism
- ☐ Macrocephaly
- ☐ Microcephaly
- ☐ Other: _____

Skeletal / Limbs / Trunk
- ☐ Skeletal dysplasia
- ☐ Vertebral anomaly
- ☐ Scoliosis
- ☐ Polydactyly
- ☐ Syndactyly
- ☐ Arthrogryphosis
- ☐ Talipes
- ☐ Other:

Pulmonary
- ☐ Cong. cystic adenomatoid malformation
- ☐ Small thoracic cavity
- ☐ Diaphragmatic hernia
- ☐ Pulmonary sequestration
- ☐ Pleural effusion
- ☐ Other: _____

Gastrointestinal
- ☐ Gastroschisis
- ☐ Omphalocele
- ☐ Tracheoesophageal fistula
- ☐ Other: _____

Genitourinary
- ☐ Ambiguous genitalia
- ☐ Hydronephrosis
- ☐ Megacystis
- ☐ Polycystic kidneys
- ☐ Renal agenesis
- ☐ Other:

Previous Karyotype
- ☐ Yes (result): _____

Family History
- ☐ Parents with ≥ 2 miscarriages
- ☐ Other relevant family history (details): _____

Other Comments:

Patient consent for de-identified clinical details and test result to be included in an international database compliant with Australian and US privacy standards?
- ☐ **Yes**
- ☐ **No**