

CHROMOSOMAL ANEUPLOIDY AND GENDER DETERMINATION

TEST REQUEST FORM

Please check: Cash / Cheque Payment On Account _____

Patient Information

Name: _____ Reference no : _____

Age: _____ Gestation week: _____

Reference laboratory/ Doctor : _____

Telephone no : _____ Fax no : _____

Clinical Details:

Test Requested:

- Chromosomes 13 , 18 , 21 & Sex Determination (QF-PCR)
- Karyotyping + Chromosomes 13 , 18 , 21 & Sex Determination (QF-PCR)
- Others / Special Request: _____

Sample Type:

- Amniotic Fluid (Recommended 25ml, 5ml for QF-PCR) Others: _____
- Chorionic Villi (Recommended 80mg, 30mg for QF-PCR)

PCR Testing Description:

This test determines aneuploidy of chromosomes 13, 18, 21 and the gender of the foetus using advanced fluorescent PCR technology. This analysis should be used as an adjunctive test to karyotyping. Please note that the presence of maternal blood in the sample may interfere with the result and interpretation and should be minimized as much as possible.

Authorized Signature: _____ Date: _____

Please call 2111 2161 for sample collection and store samples at **4°C**. Sample collection will be arranged as soon as possible.

***Remark: The general Terms and Conditions that are incorporated into this test are applied in our service.**