Products of conception (POC) test requisition form

Don't write in this grey area. For Juno Genetics internal use only	Juno Genetics number	Date of reception	Received by

**The sections marked with (*) are mandatory to fill in to request the test*

PATIENT INFORMATION		REFERRING CLINIC DETAILS	
Patient name *		Referring name clinician*	
Patient clinic number *		Clinician email *	
Patient date of birth *		Referring clinic *	
Patient email/phone number*		Email where to send the results *	

CLINICAL INDICATION *

☐ Abnormal ultrasound

☐ High-risk pregnancy as determine by: ☐ Amniocentesis ☐ Chorionic villus testing ☐ Non-invasive prenatal testing
Fetal karyotype as determined by previous prenatal test: _____

☐ Previous miscarriage(s): Number _____

☐ Aneuploid parental karyotype(s): Female patient: _____
Male patient: _____

☐ Other:_____

☐ Unknown

CLINICAL INFORMATION

Date of pregnancy loss		Estimated gestational age	_____ (weeks) _____ (days)
Type of sample	☐ Conventional curettage ☐ Spontaneous abortion ☐ Other: _____		
Conception method *	☐ Natural ☐ IUI IVF: ☐ Own eggs ☐ Donated eggs		
Type of gestation *	☐ Singleton ☐ Multiple: Number of foetuses _____		
Date of sample collection			

TEST REQUEST OF THE POC TEST BY AN AUTHORIZED HEALTH PROFESSIONAL*

I certify that I'm legally authorized to request medical examinations or use medical information, and that the patient details provided in this form are accurate to the best of my knowledge. I have explained the test and its limitations to the patient(s) and answered any related questions to the best of my abilities. I confirm that the patient has completed and signed the appropriate informed consent for the POC test and that I have a copy of it. I agree to provide any additional information requested by Juno Genetics if necessary.

Signature of authorised referrer health professional*		Date of request*	