NEO 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 *	dd / mm / yyyy	Referring clinic *	
Patient email		Email where to send the results *	

CLINICAL INDICATION *

☐ Advanced maternal age (> 35 years) ☐ Low risk/ maternal anxiety ☐ Positive serum screen ☐ Abnormal ultrasound

☐ History suggestive of increased risk for the specified chromosome aneuploidies ☐ Others_____

CLINICAL INFORMATION

Gestational age *	_____ weeks and _____ days		
Method for pregnancy dating*	☐ Last menstrual period ☐ Date of implantation ☐ Crown-rump length ☐ Other _____		
Type of pregnancy	☐ Natural ☐ IVF	Date of blood draw*	
	☐ Oocyte donation ☐ IUI	Oocyte donor Date of birth	dd / mm / yyyy
Maternal weight (kg)		Maternal height (cm)	
Type of gestation *	☐ Singleton ☐ Twin ☐ Vanishing twin		
Relevant medical information (select only if present)	☐ Recent blood transfusion ☐ Cancer ☐ Immunotherapy or stem cell therapy ☐ Mosaicism/Chimera ☐ Transplant ☐ Others_____		

TEST SELECTION

NEO5 TEST	☐	Screening for fetal aneuploidies for 5 chromosomes (13, 18, 21, X, Y). If aneuploidy is detected for twin pregnancies, it is not possible to determine which fetus is affected by the aneuploidy.
NEO24 TEST	☐	Screening for fetal aneuploidies for all chromosomes. If aneuploidy is detected for twin pregnancies, it is not possible to determine which fetus is affected by the aneuploidy.

Sex chromosomes to be reported? * ☐ Yes ☐ No

*If abnormality affecting the sex chromosomes is detected in a singleton pregnancy, the sex will be reported even if 'No' is selected. For twin pregnancies, only the presence of the Y-chromosome is reported. Sex chromosome abnormalities are not reported for twin pregnancies.

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

I certify that I'm legally authorized to request 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 selected NEO 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 *	dd / mm / yyyy

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