

Notification of Prenatal Diagnosis

(At least 2 weeks prior notification required to ensure standard TAT)

Test requested: _____

Patient Details Name: _____ D.O.B. _____

Address: _____

Sample type: CVS Amnio Extracted DNA

Collection date: _____

Gestation (weeks): _____

Requesting Practitioner Name: _____

Address: _____

Tel no: _____ Fax no. _____

Signature: _____

Clinical Information (Family history details):

Comments (special arrangements):

PLEASE NOTE: Sample Collection – Prior discussion with the laboratory is required to determine whether additional samples are needed.

Please send the completed form ASAP

FAX: (03) 8341 6366 or

EMAIL: molgen.general@ghsv.org.au

Molecular Genetics Laboratory
10th floor Royal Children's Hospital
Flemington Rd, Parkville, Vic 3052