

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 *	
<input type="checkbox"/> Advanced maternal age (> 35 years) <input type="checkbox"/> Low risk/ maternal anxiety <input type="checkbox"/> Positive serum screen <input type="checkbox"/> Abnormal ultrasound	
<input type="checkbox"/> History suggestive of increased risk for the specified chromosome aneuploidies <input type="checkbox"/> Others _____	

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

TEST SELECTION	
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? * <input type="checkbox"/> Yes <input type="checkbox"/> 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