Prenatal Diagnostic Laboratory, Tsan Yuk Hospital

Address: Rm. 210, 30 Hospital Road, Hong Kong Tel: 25892218 Fax: 25172373

HKU Med School of Clinical Medicine Department of Obstetrics & Gynaecology 香港大學婦產科學系

REQUEST FORM FOR LABORATORY STUDIES
PRENATAL DIAGNOSIS / REPRODUCTIVE MEDICINE INVESTIGATION

PATIENT DETAILS

Clinic / Hospital No.:

Surname / Last Name *(please affix gum label or complete in full)* 中文姓名

Given Name(s) / First Name(s)

HKID / Document ID **Date of Birth** (DD-MM-YYYY) **Age** **Gender** ☐Female ☐Male

Consanguinity? **PDC No.:**

Wife of / Husband of / Partner of:
(Please delete where appropriate)

REFERRING DOCTOR DETAILS

Name (Print / Staff Name Chop)

Tel: Fax:

Address:

Referring institute Ward / Clinic

SPECIMEN DETAILS

Date & Time of Sampling DD-MM-YYYY,(HH:MM))

Previous Report No.

☐Amniotic fluid ☐Chorionic villi ☐Placental tissue ☐Skin biopsy ☐Products of gestation
☐Foetal blood ☐Maternal blood ☐Paternal blood ☐Peripheral blood ☐Others:

TESTS REQUESTED

☐Chromosomal microarray
QF-PCR for chromosome
☐13 ☐18 ☐21
☐XY ☐Del22q11.2
☐Karyotype
☐Y-microdeletion
☐Fragile X testing
☐Genetic testing for
☐UPD testing for chromosome
☐Methylation PCR for
☐FISH for
☐Others:
☐Save DNA ☐Cryo-freeze cells ☐Keep cells in culture (1 month)

CLINICAL DETAILS
For prenatal diagnosis:

L.M.P.: DD-MM-YYYY E.D.C. by scan: DD-MM-YYYY Gestation by scan: wk d

☐Abnormal DS screening: HA / private, 1st tri / 2nd tri DS, Risk 1 in Report No.:
☐NIPT: HA / private, result Report No.:
☐Anxiety ☐Advanced maternal age ☐Translocation carrier ☐ α thalassaemia couple ☐ β thalassaemia couple
☐Previous child with chromosome abnormality:
☐Family history of chromosomal/genetic disorder:
☐Others:

Ultrasound findings:

Neurological:
☐Abnormal gyration
☐Agenesis of the corpus callosum
☐Cerebellar hypoplasia
☐Dandy Walker malformation
☐Decreased fetal movement
☐Holoprosencephaly
☐Hydrocephalus
☐Neural tube defect
☐Ventriculomegaly
☐Others:

Craniofacial:
☐Aplasia/Hypoplasia of nasal bone
☐Cleft lip
☐Cleft lip and cleft palate
☐Cleft palate
☐Hypertelorism
☐Hypotelorism
☐Macrocephaly
☐Microcephaly
☐Others:

Cardiac:
☐Aortic atresia ☐ASD
☐Atrioventricular canal defect
☐Coarctation of the aorta
☐Dextrocardia
☐Double outlet right ventricle
☐Ebstein anomaly
☐Echogenic intracardiac focus
☐Hypoplastic left heart
☐Hypoplastic right heart
☐Pulmonary valve atresia
☐Situs inversus
☐Tetralogy of Fallot
☐Transposition of the great vessels
☐Truncus arteriosus ☐VSD
☐Others:

Pulmonary:
☐CPAM
☐Diaphragmatic eventration
☐Diaphragmatic hernia
☐Pleural effusion
☐Pulmonary sequestration
☐Others:

Gastrointestinal:
☐Absence of stomach bubble
☐Anal atresia
☐Ascites
☐Echogenic bowel
☐Gastroschisis
☐Meconium ileus
☐Omphalocele
☐Tracheoesophageal fistula
☐Others:

Musculoskeletal:
☐Abnormal vertebral morphology
☐Abnormal thorax morphology
☐Acromelia
☐Club foot ☐Clenched hands
☐Contractures (arthrogryposis)
☐Limb anomaly
☐Mesomelia ☐Micromelia
☐Polydactyly ☐Syndactyly
☐Scoliosis
☐Short long bone
☐Skeletal dysplasia
☐Others:

Genitourinary:
☐Ambiguous genitalia
☐Congenital posterior urethral valves
☐Hydronephrosis
☐Kidney malformation
☐Megacystis
☐Polycystic kidneys
☐Renal agenesis
☐Urethral obstruction
☐Ureteral obstruction
☐Others:

Others :
☐Fetal cystic hygroma
☐Hydrops fetalis
☐Increased nuchal translucency (_____mm)
☐IUGR
☐Oligohydramnios
☐Polyhydramnios
☐Single umbilical artery
☐Others:

For reproductive medicine investigation: ☐Recurrent miscarriage ☐Primary ovarian insufficiency
☐Primary testicular failure ☐Oligospermia (severe; ≤2 million/mL) ☐Azoospermia
☐Family history of chromosomal disorder: (Previous Report No.:)
☐Others:

Please complete the patient consent form and return it to the laboratory with this request form.

Referring doctor's signature: **Request date** DD-MM-YYYY:

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Name: _____

HKID / Document ID: _____

(or GUM LABEL)

LABORATORY USE ONLY **Duty Officer:**

Date and Time of sample receipt: