BIOGENIX LABS
By M42

G42 Healthcare - Omics Center of Excellence (Biogenix Labs)
Masdar City - Abu Dhabi
Contact: +971 58 166 1261
Email: clinical.genomics@m42.ae

For scanning and accuracy, affix patient label within this outlined box.

Patient Name:

MRN No:

Only use black ball point pens to ensure scanning integrity.
No sharpies, highlighters, or red ink please.

Non-Invasive Prenatal Testing Test Requisition Form

Referring Hospital & Clinician Details			
Hospital Name			
Ordering Clinician's Name		Health Authority and License No.	
Email ID		Phone Number	
Assisting Clinician Details			
Name		Phone Number	
Email ID			

Patient Details			
Full Name			
Date of Birth	DD/MM/YYYY	Age	
Emirates ID or Passport # (specify Citizenship in case of passport)		Phone Number	
Email ID			

Clinical Information

Date of Blood Draw DD/MM/YYYY	Gestation Weeks/Days	Estimated Due Date DD/MM/YYYY	Maternal Weight (kg)	Maternal Height (cm)	BMI

Single Pregnancy	○
Twin Pregnancy	◉

Test Request
6000048 NIPT Core, with gender
6000049 NIPT Core, without gender
6000050 NIPT Comprehensive, with gender
6000051 NIPT Comprehensive, without gender

Core (Common Trisomies): Tests for Trisomy 21, 18, 13, and sex chromosome aneuploidies (SCAs) with the gender option.
Comprehensive (Genome-wide): Includes all autosomal aneuploidies, rare trisomies (e.g., chromosomes 22, 16), microdeletion syndromes (e.g., DiGeorge, Prader-Willi), copy number variants (CNVs ≥7 Mb) and SCAs with gender the option.

Test Indications		Patient's Medical History	
Advanced Maternal Age	No Yes	Received allogeneic blood transfusion	☐ No ☐ Yes, when?
Parental Anxiety	No Yes	Received heparin therapy	☐ No ☐ Yes, when?
Abnormal results of other prenatal screening tests	☐ No ☐ Yes, Please specify	Received immunotherapy and/or human serum albumin therapy	☐ No ☐ Yes, when?
Abnormal Reproductive History	☐ No ☐ Yes, Please specify	Diagnosed with vanishing twin syndrome	☐ No ☐ Yes, When?
Previous pregnancy affected by chromosomal/genetic disorder	☐ No ☐ Yes, Please specify	Received assisted reproductive technology treatment	☐ No ☐ Yes, when?
Family history of genetic disorder/s or syndrome	☐ No ☐ Yes, Please specify	History of Bone Marrow Transplant	☐ No ☐ Yes, when?

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Referring Clinician's Statement

☐ I acknowledge that the sample may not meet the acceptance criteria for the following reasons:

- Samples arrive after 48 hours.
- Gestational age below 10 weeks.
- BMI over 40.

I understand that these factors may affect the accuracy or validity of test results.
I will ensure that my patient is aware of these considerations and is willing to proceed with the testing.

☐ Not Applicable

☐ I verify that the patient and prescriber information in this form is complete and accurate to the best of my knowledge and that I have requested this screening test based on my professional judgement of medical necessity. I confirm that the patient understands the purpose, limitations, potential risks, scope and performance of this test and that I have answered any questions to the best of my ability.
The patient has provided informed consent for this test.

Name of Physician		Signature	
Date	DD/MM/YYYY	Place	

Collection Information

Collection Date	DD/MM/YYYY	Collection Time	☐ AM ☐ PM
Sample Type	☐ Peripheral Blood ☐ Plasma	Collector's Signature	

Billing Details

☐ Client Billed ☐ Patient Billed ☐ Insurance Billed
(Submit EID and Insurance Card)

Receiving Lab Information

Laboratory Access Number		Date Received	DD/MM/YYYY