Center for Transfusion Medicine and Hemotherapy
University Medical Center Giessen Langhansstrasse 7
· 35392 Giessen · GERMANY

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Patient

Surname

First name

Date of birth Sex ☐ m ☐ f

Street, number

Postcode City

Country

Ethnic origin

Supervising physician

Titel, surname, first name

Office/Medical Center

Street, number

Postcode City

E-Mail

Phone fax

Country Signature

Order, non-invasive fetal blood group genotyping

☐ RHD ☐ Other (e.g. K, HPA-1a), specify:

* Before shipping a sample, please call ☎ +49-641-985-41544 or 41525
* NIPT is a genetic test and – if carried out in Germany – subject to the German Genetic Diagnostics Act (GenDG). The order form is only valid in combination with genetic counceling and a signed informed consent (see reverse side).

Payment

According to German Med Fee Schedule: RHD (TaqMan) 160,89 €; Other (NGS) 566,56 €

The patient will receive an invoice from the clearinghouse BüdingenMed.

Testing Material

Exclusively 20 ml venous blood (2 BCT tubes, Streck®) plus 10 ml native blood without anticoagulant.
Please invert tubes 10 times. Do not open the tubes. Do not freeze the specimens. Keep tubes at room temperature.
Testing material should arrive in the laboratory within 48 hours after sampling.

Mandatory field

Gravida: Para: Due date: . . Week of gestation (week+day)

☐ Single pregnancy ☐ Twin or multiple pregnancy

☐ Oocyte donation RhD prophylaxis (where applicable) . . ABO, Rh blood group:

Clinical question, patient history

In case of fetal/neonatal alloimmunthrombocytopenia in previous pregnancy

Platelet count of the newborn: Intracranial hemorrhage ☐ yes ☐ no ☐ unknown

Previous diagnostic reports:

(Latest antibody identification; latest antibody titer; relevant blood-group genetics; blood-group genetics of the partner (zygosity); blood-group genetics of the offspring(s); please provide copies of reports)

Prof. G. Bein, MD
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University Medical Center Giessen
Langhansstraße 7 · 35392 Giessen · GERMANY

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Required field:

Dear Patient,

German Genetic Diagnostics Act (GenDG (§10)) requires the patient to be fully informed, a written Informed consent and in case of prenatal testing detailed genetic counseling.

Please read this information carefully and delete statements you do not agree with.

I agree/confirm that I

- was informed about type, chances, risks, limitations and significance of the non-invasive fetal blood group genotyping according to German GenDG by the supervising physician. There was adequate time to ask questions.
- understood that the sensitivity and specificity of the test is > 99%. However, false positive or false negative predictions of the fetal phenotype cannot be excluded
- gave my permission for blood sampling required for the analysis.
- give my permission to perform the non-invasive fetal blood group genotyping with my sample.
- consent to the storage of my blood sample after the analysis is performed, without claiming storage.
- consent to my blood sample to be utilized anonymously for scientific purposes and quality management.
- Moreover, I was informed that
- I can stop the analysis at any time, asking for the elimination of all results.
- I can withdraw my Informed Consent in total or in part at any time without any reason.
- I have to pay for the costs of the analysis that were generated until my withdrawal.
- I have the right not to know the results of the analysis (right not to know).
- the genetic analysis and possible findings are focussed on the medical indication given above and no statements are made about other diseases.

_____

Place, date

_____

Patient's signature

Required field:

Disclosure and genetic counseling for the non-invasive fetal blood group genotyping according to German Genetic Diagnostics Act (GenDG) to be completed by the supervising physician

I agree/confirm that

- the pregnant woman was informed about non-invasive fetal blood group genotyping according to German Genetic Diagnostics Act (GenDG (§9))
- the pregnant woman was genetically counselled according to German Genetic Diagnostics Act (GenDG (§10))

_____

Place, date

_____

Print surname, first name, institution, mailing address

_____

Supervising physician's signature