Canterbury District Health Board
Te Poari Hauora ō Waitaha
CHRISTCHURCH WOMEN'S HOSPITAL
MATERNITY SERVICES

SURNAME ..... NHI .....
FIRST NAME ..... DOB .....
ADDRESS .....
..... POSTCODE .....
*(or affix patient label)*

INFO FOR PRENATAL/PERINATAL MICROARRAY

# Information to Accompany Request/Sample for Prenatal/Perinatal Microarray

| | |
|---|---|
| **Sample type(s)** | ☐ CVS ☐ AF ☐ Placenta ☐ Fetal tissue ☐ Blood ☐ Other:_____ |
| **Gestation** | |
| **Ultrasound findings** | |
| **Indication for Microarray** | |
| **Family history** | |
| **Partner** | Name: |
| | DOB: |
| | NHI: *(if known)* |
| **Blood sample** | • Is the maternal blood sample accompanying the sample? (**REQUIRED** for Prenatal (CVS/AF) and Perinatal (Placental) samples) ..... ☐ Yes ☐ No<br>• Is the paternal blood sample accompanying the sample (Prenatal only)? ..... ☐ Yes ☐ No<br>If paternal blood sample not available, please state reason: |
| **Requesting obstetrician / clinical geneticist** | Name: |
| | Phone number: |
| **Date of sampling** | |
| **Collected by** | |
| **LMC** | Name: |
| | Phone number: |

**Is the patient consent form signed and attached:** ☐ Yes

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