Department of Obstetrics and Gynaecology

PGD Lab, 4/F, Block K, DTB, Prince of Wales Hospital,
The Chinese University of Hong Kong
Shatin, N.T., Hong Kong, SAR
Tel: (852) 3505 1557 | Fax: (852) 3505 4810 | www.obg.cuhk.edu.hk

Name: _____ (Surname) _____ (Name) Chinese: _____

Date of birth: ____ (DD) / ____ (MM) / ____ (YYYY) Sex: F/ M

HKID: _____ ( )

Hospital/ Clinic no.: _____

Address: _____

Fees paid by: ☐ Patient ☐ Referral doctor ☐ HA

Patient Label

Sample collection date: ____ (DD) ____ (MM) ____ (YYYY)

Sample collection time: _____

Referral Hospital/ Clinic: _____

Phone: _____ Fax: _____

Referral doctor: _____

Signature: _____

Clinical history

Gestational age: ____ wks ____ days (EDC by US date: _____ by LMP date: _____) Gravida: _____

☐ Advanced maternal age ☐ Translocation carrier: _____ ☐ Previous child/ pregnancy with chr abn: _____

☐ Recurrent abortion ☐ Miscarriage ☐ Familial chr. abn.: _____ ☐ Others: _____

☐ Fetal anomalies (pls specify): _____

☐ Positive Down screening: Risk: _____ ☐ Non-invasive prenatal screening: _____

Specimen type

☐ Amniotic fluid ☐ Chorionic villi ☐ Placental tissues ☐ Blood: (Patient/ Maternal/ Paternal/ Fetal/ Cord)

☐ Others: _____

Test requested

☐ Karyotyping ☐ QF-PCR for chr. 13,18,21,X &Y ☐ UPD chr: _____ ☐ FISH: _____ ☐ PCR for Y chr. microdeletion

☐ CMA: Fetal DNA Chip v2.0 ☐ FetalSeq v1.0 (☐ with parental samples) ☐ Fragile X PCR assay

☐ PCR for 22q11.2 microdeletion ☐ Hearing loss screening ☐ α- and β-thal common mutation screening (5 α+16 β)

☐ Other test: _____

Previous study: ☐ Yes: Lab no.: _____ ☐ No ☐ Remarks: _____

This part for laboratory use only

Specimen received on: ____ (DD) ____ (MM) ____ (YYYY) Time: ____ (hh) : ____ (mm) Laboratory no.: _____

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CONSENT FORM
同意書

Patient or Guardian
病人或監護人

* I consent / do not consent to be tested for genetic test/tests which have been explained to me
* 本人同意 / 不同意進行已向本人解釋過的基因測試
* I consent / do not consent for materials from this sample to be stored / used anonymously for relevant research
* 本人同意 / 不同意從測試中抽取的樣本可被儲存或不具名地用作其他有關的研究

Signed 簽署: _____
Date 日期 (dd/mm/yyyy): / /

** Please cross-out where applicable*
* 請將不適用者刪去

Doctor
醫生

I have explained the purpose of obtaining a blood or tissue sample for genetic testing
本人已解釋收取血液或組織樣本作基因測試的目的

Signed 簽署 _____
Date 日期 (dd/mm/yyyy): / /

This consent form is used with diagnostic testing. Please contact our Professor if you have queries about this consent or counselling issues.
此同意書與診斷測試一起使用。如有任何關於此同意書或診症方面的問題，請聯絡本系的教授。