Non-Invasive Prenatal Testing (NIPT) Report

Patient information		
Full name:		
Date of birth:	Weeks of gestation:	
Patient ID:	Contact number:	
Email:	Referred by (Dr. / Physician):	
Test details		
Medical institution name:		
Medical institution address:		
Medical institution contact information:		
Lab technician:	Lab ID or location:	
Date sample collected:	Date of report:	

NIPT results

Fetal chromosomal analysis
Instructions: Select if detected.
☐ Trisomy 21 (Down syndrome)
Notes:
☐ Trisomy 18 (Edwards syndrome)
Notes:
☐ Trisomy 13 (Patau syndrome)
Notes:
☐ Monosomy X (Turner syndrome)
Notes:

☐ Triploidy				
Notes:				
☐ Sex chromosome aneuploidies				
Notes:				
Other tests:				
Notes:				
Fetal fraction perce	entage			
A fetal fraction above	e the threshold	l indicates a sufficie	ent amount of fetal DNA for analysis	
Results:	%			
Fetal sex determination (optional)				
☐ Female	Male	Not determined		
NIPT result interpretations Risk assessment				
Nisk ussessment				
☐ Low risk	High risk Indeterminate			
Additional notes				
Physician signature:			Date:	
Patient signature:			Date:	