Non-Invasive Prenatal Testing (NIPT) Report

Medical Institution Details

Name: _____
Address: _____
Phone Number: _____
Website: _____

Patient Information

Full Name: _____
Date of Birth: _____
Weeks of Gestation: _____
Patient ID: _____
Contact Number: _____
Email Address: _____
Referred by Dr./Physician: _____

Test Details

Date Sample Collected: _____
Date of Report: _____
Lab Technician: _____
Lab ID or Location: _____

NIPT Results

- **Fetal Chromosomal Analysis: (Select if detected)**

☐ Trisomy 21 (Down syndrome)

☐ Trisomy 18 (Edwards syndrome)

☐ Trisomy 13 (Patau syndrome)

☐ Sex Chromosome Aneuploidies

☐ Additional Findings (if any): _____

- **Fetal Sex Determination (optional):**

☐ Male

☐ Female

☐ Not Determined

- **Fetal Fraction Percentage:**

- _____% (A fetal fraction above the threshold indicates a sufficient amount of fetal DNA for analysis)

Interpretation

- **Risk Assessment:**

☐ Low Risk

☐ High Risk

☐ Indeterminate

- Please note that NIPT is a screening test and not diagnostic. Further diagnostic testing such as amniocentesis may be recommended for high-risk results.

Comments

Recommendations

☐ Follow-up with genetic counseling

☐ Consider additional diagnostic testing

☐ Schedule follow-up appointment

☐ Other recommendations: _____

Physician's Signature: _____ Date: _____

Patient Acknowledgment
I have been informed of the results and understand the recommendations provided.

Patient's Signature: _____ Date: _____