Department of Obstetrics and Gynaecology

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Patient name: _____ (Last name) _____ (First name) Date of birth: ____ (DD) ____ (MM) ____ (YYYY)

Indication for Postnatal FetalSeq v1.0 analysis

Please provide the following clinical information regarding the patient to be tested. If answering "yes," please provide details as possible. Please also submit a clinic note if available. This information may help the interpretation of Postnatal FetalSeq v1.0 result.

Features	No	Yes	(Details)	Not known
Autism/Autistic spectrum	☐	☐		☐
Developmental delay	☐	☐		☐
Dysmorphic features	☐	☐		☐
Failure to thrive	☐	☐		☐
Hypotonia	☐	☐		☐
Microcephaly	☐	☐		☐
Macrocephaly	☐	☐		☐
Speech delay	☐	☐		☐
Seizure disorder	☐	☐		☐
Short stature	☐	☐		☐
Structural brain abnormalities	☐	☐		☐
Others (Please specify):				