Preimplantation genetic testing requisition form

Patient information (female)		Patient information (male)	
Full name:		Full name:	
Date of birth:		Date of birth:	
ID / Passport No:		ID / Passport No:	
Insurance:		Insurance:	

Protocol ID:	
Referral reason, indication:	
Requested preimplantation genetic testing : □ Aneuploidy (PGT-**A**) □ Structural rearrangement (PGT-**SR**) □ Monogenic disease (PGT-**M**)	

Information on the scope of accreditation at www.repromedalab.cz

Sample information:	□ Trophectoderm □ Other-specify: □ Blank
No of samples:	
No of embryos:	
List of samples:	
Requested to examine samples:	
Used germ cells:	□ Own □ Donated oocytes □ Donated sperms □ Donated oocytes & sperms

Comments - additional notifications for the laboratory (translocation, other structural aberrations, monogenic disease,...)

Sample collection and hand over information	
Date of embryo biopsy:	
Informed consent of the patient signed and attached: □ yes / □ no	
Karyotypes of both partners available and passed on the PGT laboratory: □ yes / □ no	
Date and time of sample hand over:	
Handed over by (name and signature):	

Sample transport information	
□ Reprometa s.r.o. (name and signature)	
□ Package delivery company	
□ Other	

Delivery of samples to the laboratory	
Date and time:	
Transport temperature:	□ meet the requirements □ out of the requirements
Samples accepted by:	

Contact information for results reporting (name, e-mail, phone):	**Language of the results reporting:** □ Czech / □ English / □ German

IVF clinic and referring embryologist	
Name:	
Clinic:	
Address:	
Country:	
Phone:	
E-mail:	

Date: Signature: