Pre-Preimplantation Genetic Testing for Monogenic Disorders (PGT-M) Test Requisition Form

Samples will only be processed if all mandatory fields (in blue and italics) have been completed

PATIENT INFORMATION

Patient Surname _____ *Patient Name* _____

Patient date of birth _____ *Unique patient ID* _____

Partner Surname _____ *Partner Name* _____

Partner date of birth _____ *Unique partner ID* _____

Address _____

City/Town _____ Country _____ Postcode _____

Telephone Number _____ Email address _____

FERTILITY CLINIC INFORMATION

Fertility clinic name _____ *Date of test request* _____

Clinician ordering test _____ *Clinician email* _____

- Complete the following fields **only** if not already registered with Igenomix UK

Fertility clinic address _____

City/Town _____ Country _____ Postcode _____

Telephone Number _____ Email address _____

CYCLE INFORMATION

Confirm cycle type: ☐ *Frozen cycle* *Date of expected oocyte retrieval/thaw* _____

Confirm specimen type: ☐ *Day 5/6 (Trophectoderm)*

REASON FOR REFERRAL

Patient

Last name/ Name

Date of Birth: *Relation to embryo*

Please specify the presence (if any) of a blood borne transmitted disease

Genetic disorder	Gene	Mutation
Disorder 1:	*1:*	*1:*
OMIM No.	OMIM No.	*Genetic status (e.g. Unaffected):*
Disorder 2 (If available):	*2:*	*2:*
OMIM No.	OMIM No.	*Genetic status (e.g. Unaffected):*

Partner

Last name/ Name

Date of Birth *Relation to embryo*

Please specify the presence (if any) of a blood borne transmitted disease

Genetic disorder	Gene	Mutation
Disorder 1:	*1:*	*1:*
OMIM No.	OMIM No.	*Genetic status (e.g. Unaffected):*
Disorder 2 (If available):	*2:*	*2:*
OMIM No.	OMIM No.	*Genetic status (e.g. Unaffected):*

Family member 1

Last name/ Name

Date of Birth *Relation to embryo*

Please specify the presence (if any) of a blood borne transmitted disease

Genetic disorder	Gene	Mutation
Disorder 1:	*1:*	*1:*
OMIM No.	OMIM No.	*Genetic status (e.g. Unaffected):*
Disorder 2 (If available):	*2:*	*2:*
OMIM No.	OMIM No.	*Genetic status (e.g. Unaffected):*

Family member 2

(If available)

Last name/ Name

Date of Birth *Relation to embryo*

Please specify the presence (if any) of a blood borne transmitted disease

Genetic disorder	Gene	Mutation
Disorder 1:	*1:*	*1:*
OMIM No.	OMIM No.	*Genetic status (e.g. Unaffected):*
Disorder 2 (If available):	*2:*	*2:*
OMIM No.	OMIM No.	*Genetic status (e.g. Unaffected):*

Family member 3

(If available)

Last name/ Name

Date of Birth *Relation to embryo*

Please specify the presence (if any) of a blood borne transmitted disease

Genetic disorder	Gene	Mutation
Disorder 1: OMIM No.	*1:* OMIM No.	*1:* *Genetic status (e.g. Unaffected):*
Disorder 2 (If available): OMIM No.	*2:* OMIM No.	*2:* *Genetic status (e.g. Unaffected):*

CLINICIAN AUTHORISATION

It is the referring clinician's responsibility to ensure that the patient/carer knows the purpose of the test and that the sample(s) may be stored for future testing related to specific diagnosis for the patient. In signing this form, the clinician confirms that they have obtained consent for testing and storage. The patient should be advised that the clinical information/sample(s) may be used anonymously for audits, quality assurance, research, and training purposes. Please advise of any restrictions.

Clinician signature:	*Date:* Click or tap to enter a date.

FOR IGENOMIX UK USE ONLY

Please fill sample reception table:		
Received by:	*Time:*	*Date:*
Sample accepted/rejected: *If rejected, state the reason:*		