Requisition form for PGT-A, PGT-SR, PGT-M & MitoScore tests

The fields marked with * are mandatory to carry out the test

***ANALYSIS REQUESTED**

☐ **PGT-A (PGS)** ☐ **PGT-M** ☐ **PGT-SR (Structural rearrangements)**

Would you like to request MitoScore? : ☐ **Yes** ☐ **No**

Only available if PGT-A and/or PGT-SR are chosen. If none of the above options are selected, the MitoScore value will be reported

CLINICIAN INFORMATION

*Clinic/Hospital/Medical Practice:_____

*Referring Doctor: _____

IVF Lab Manager: _____*Contact person: _____

Email or telephone number: _____ *Email address for delivery of results: _____

Address: _____

City: _____ County/Province/State: _____ Postcode: _____

DETAILS OF PATIENT(S)

*Unique Patient ID (1):_____ **(1):** If there is none, please state NOT APPLICABLE

*Patient's name:_____*Surname(s):_____*Date of birth:_____

*Partner's name:_____*Surname(s):_____*Date of birth:_____

*Karyotype(s) (2): ☐ Patient_____ ☐ Partner _____

(2): The karyotype of the carrier will only be required if the PGT-SR is selected

CYCLE INFORMATION

☐ Own eggs ☐ Donor eggs ☐ Own sperm ☐ Donor sperm

Date of egg retrieval: _____ # of Fertilised eggs: _____ # of Biopsied embryos: _____

Fertilisation method: ☐ IVF ☐ ICSI

*Expected date of biopsy: _____

*Date/time planned for embryo transfer (3):_____

(3) Only mandatory for transfers in the same cycle

*Embryo transfer: ☐ Fresh cycle (transfer in the same cycle) ☐ Frozen cycle (transfer in other cycle)

*Type of biopsy: ☐ Day-3 Blastomere ☐ Day 5/6/7 Trophectoderm

Doctor authorisation

I certify that the information of the patient and the referring clinician on this form is correct to the best of my knowledge and that I have requested the above test based on my professional judgement. I have explained the limitations of this test and I have answered any questions. I understand that Igenomix may need additional information and I agree to provide this information if necessary.

Doctor's signature_____ Date: _____/_____/_____

Request form for PGT-A, PGT-SR, PGT-M & MitoScore tests

*Unique Patient ID(1): _____ *Patient Name and Surname:_____

(1): If there is none, please state NOT APPLICABLE

*Indication(s):

PGT-A

- ☐ Advanced maternal age
- ☐ Previous aneuploidy pregnancy
- ☐ Implantation failure (# of failures____)
- ☐ Male factor
- ☐ Recurring miscarriage (# of miscarriages___)
- ☐ Sex-linked disorders
- ☐ Abnormal sperm FISH result

PGT-SR

- ☐ Altered karyotype
- ☐ Translocation
- ☐ Inversion
- ☐ Numerical abnormality

Karyotype: _____

PGT-M

☐ Monogenic diseases (please state):_____

PGT-A; PGT-SR; PGT-M

Other indications: _____

*SAMPLE DETAILS

Embryologist 1 full name:_____ Embriologist 3 full name:_____

Embriologist 2 full name:_____ Embriologist 4 full name:_____

*Date of biopsy D3_____ /D5_____ /D6_____ Lot no. of wash/tubing buffer used: _____

Embryo ID			Morphological classification of embryo	Origin					Date of biopsy				Visible nucleus		Embryologist initials		Comments
Patient initials	Embryo no.	Tube ID		Fresh egg	Vitri egg	D2 Vitri	D3 Vitri	Vitri blasto	D3	D5	D6	Rebiopsy	YES	NO	Biopsy	Tubing	

FOR IGENOMIX USE ONLY

Received by:	Date/Time:
Sample accepted/rejected (provide reason if rejected):	