Igenomix®

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

The fields marked with * are mandatory to perform the test

***ANALYSIS REQUESTED**

☐ **PGT-A** ☐ **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, MitoScore 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:______________________ If unavailable, 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 PGT-SR is selected

CYCLE INFORMATION

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

Egg retrieval date: ________________ # of Fertilised eggs: __________ # of Biopsied embryos: ____________

Fertilisation method: ☐ IVF ☐ ICSI

*Expected date of biopsy:__________ (Only mandatory if TRF is unaccompanied by biopsy worksheet)

*Date/time planned for embryo transfer:______________________________ (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

Clinician 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.

Clinician's signature______________________________ Date: ______/____________/__________

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*Unique Patient ID[1]: ____________________ *Patient Name and Surname:_____________________________________

(1): If unavailable, please state NOT APPLICABLE

*Indication(s):

PGT-A

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

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 & BIOPSY WORKSHEET

Embryologist 1 full name:___________________________ Embryologist 3 full name:___________________________

Embryologist 2 full name:___________________________ Embryologist 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):	

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