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)

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:_____

Patient ethnic group. Please select all that apply.

☐ Caucasian ☐ East Asian ☐ South Asian ☐ Arab/ME ☐ Other_____

☐ Ashkenazi J. ☐ Hispanic ☐ Romani ☐ Afro-_____ ☐ Unknown

*Karyotype(s) (1): ☐ Patient_____ ☐ Partner _____

(1): 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 (if using own eggs): _____

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

*Unique Patient ID[2]: _____ *Patient Name and Surname:_____

(2): 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 (please state here if research/study sample) :_____

***SAMPLE DETAILS & BIOPSY WORKSHEET**

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

Embryologist 2 full name:_____ Embryologist 4 full name:_____

*Date of biopsy D5_____ /D6_____ /D7_____ Lot no. of wash/tubing buffer used:_____

Embryo ID			Morphological classification of embryo	Origin egg			Origin biopsy		Day of Biopsy	Re-biopsy	Embryologist initials		Comments[4]
Patient initials	Embryo no.	Tube ID[3]		Fresh egg	Vitri egg	Donor egg	Fresh blast	Vitri blast			Biopsy	Tubing	

(3) This the number on the side of the tube provided by Igenomix.

(4) If using donor egg(s), please write the age of the donor in the comments section. Please also note here date for D3 biopsy, if required.

FOR IGENOMIX USE ONLY

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

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