CGT Test Request Form

Fields with * are required to carry out the test

ANALYSIS REQUESTED*

1. CGT panels associated with the shipment of a biological sample

- ☐ **CGT Bank**
- ☐ **CGT Plus** ☐ **CGT Plus couple** (2 individuals)
- ☐ **CGT Exome** ☐ **CGT Exome couple** (2 individuals)
- ☐ **CGT Mirror** ☐ **CGT Mirror Couple** (2 individuals) *Indicate panel _____
- ☐ **CGT Sync**[1] Indicate Genes* _____

[1] For **female** patients only for genes indicated above. Include analysis of X-linked genes? ☐ **YES** ☐ **NO**

2. No biological sample needed (associated to CGT test already performed)

- ☐ **CGT Sync Reanalysis** Indicate genes* _____
- ☐ **Report Upgrade to Plus**
- ☐ **Report Upgrade to Exome**
- ☐ **Report Upgrade to Mirror** *Indicate Panel _____

DETAILS OF CLINICIAN REQUESTING STUDY

* Clinic:

* Referring Doctor:

* Email for results delivery:

Individual 1 - Details

Medical Record Number (MRN)/ ID: _____

*First name: _____ * Surname: _____

*Date of birth: _____ *Email: _____

*Sex: ☐ Male ☐ Female

Ethnic group **(please indicate).** If the patient belongs to more than one ethnic group, please indicate below.

☐ Caucasian ☐ Ashkenazi ☐ East Asian ☐ Hispanic ☐ South Asian
☐ GRT ☐ Arab ☐ African/Caribbean ☐ Unknown ☐ Other (Please specify): _____

Individual 1 - Clinical Details

*Sample date: _____ Extraction performed by (full name): _____

*Sample type: ☐ Blood ☐ Saliva ☐ DNA



Tube label code (QR code): _____

*Individual 1 is a DONOR? ☐ Yes ☐ (a) Consent form of Donor not provided (Liability disclaimer; check the box if not provided) ☐ No

*Relevant clinical information for the test (if applicable):

☐ Allogenic bone marrow or hematopoietic stem cell transplant ☐ Recent blood transfusion (<60 days) ☐ Congenital or acquired chimera
Days since last transfusion _____

*Test specification:

☐ No family history ☐ With family history (1) ☐ Known carrier (1) (1) Specify gene: _____
(Attachment of clinical report(s) recommended)

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Individual 2 - Details

Medical Record Number (MRN)/ ID: _____

*First name: _____ * Surname: _____

*Date of birth: _____ *Email: _____

*Sex: ☐ Male ☐ Female

Ethnic group **(please indicate).** If you belong to more than one ethnic group, please indicate below.

☐ Caucasian ☐ Ashkenazi ☐ East Asian ☐ Hispanic ☐ South Asian
☐ GRT ☐ Arab ☐ African/Caribbean ☐ Unknown ☐ Other (Please specify) _____

Individual 2 - Clinical Details

*Sample date: _____ Extraction performed by (full name): _____

*Sample type: ☐ Blood ☐ Saliva ☐ DNA



Tube label code (QR code): _____

*Individual 2 is a DONOR? ☐ Yes ☐ (a) Consent form of Donor not provided (Liability disclaimer; check the box if not provided) ☐ No

*Relevant clinical information for the test (if applicable):

☐ Allogenic Bone marrow or hematopoietic stem cell transplant ☐ Recent blood transfusion (< 60 days) ☐ Congenital or acquired chimera

Days since the last transfusion _____

*Test specification:

☐ No family history ☐ With family history (2) ☐ Known carrier (2) (2) Specify gene: _____

(Attachment of clinical report(s) recommended)

CONSANGUINITY

Is there consanguinity between Individuals 1 and 2? ☐ Yes Relationship: _____ ☐ No

CLINICAL INFORMATION (Add here any additional relevant information you want to share)

DOCTOR / GENETIC COUNSELLOR / CLINICAL STAFF AUTHORISATION

I certify that the information on this requisition form is correct to the best of my knowledge and that I have requested the above test based on my professional judgement of clinical indication. I have explained the limitations of this test and I have answered any question with my medical judgement. I understand that Igenomix (Part of Vitrolife Group) may need additional information and I agree to provide this information if necessary. The clinic has obtained the express consent of individuals #1 and #2 to perform the requested test and to process their data.

*Signature: _____ Date: _____

(a) The clinic stores and safeguards the patient's informed consent to carry out this test in accordance with the criteria and Consent information form provided by Igenomix. The donor has been informed that their DNA may be sequenced for a greater gene content than those included in the CGT Panel. It may be necessary to examine the data from these additional genes for matching purposes to compare the DNA results with another individual's data. The donor hereby authorizes the performance of further genetic matching analyses. The clinic will be responsible for sending the analysis results to the donor, in case they request to receive them. The donor acknowledges that such results might evidence certain risk(s) of transmitting hereditary disorders to their offspring, even if they show no symptoms of such disorders. If the informed consent is withdrawn from the clinic by the patient, this change must be communicated to Igenomix. It is understood that if such withdrawal occurs after the CGT test has been performed IGENOMIX may use my genetic data in their information systems if they remove any association to my identity and use it solely for research purposes.

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