CarrierTest Request Form

PATIENT INFORMATION	REPORTING RECIPIENTS
Name and surename: Insurance number: Date of birth: Male ☐ Female ☐ Insurance in Czech Republic: _____ Self payer ☐ Address: Email:	Ordering physician: Institution name: Phone: Email:

Primary sample: **Sampling date/time:**

☐ Perrifer blood in K_3EDTA

Clinical data:

☐ Egg / Sperm Donor ☐ Male Infertility / Female Infertility

☐ Consanguinity ☐ Family history

Details:

☐ **CarrierTest - pre-conception panel** (trombosis Profile, Carrier of recessive mutations, response to FSH stimulation)

☐ **CarrierTest compatibility with partners**

Name: _____ **Date of birth:** _____

☐ Samples sent together

Informed consent* – the patient agrees with:

AGREE ☑ with sample examination DISAGREE

☐ use for internal/external quality control

☐ requires examination of random findings ☐ requires sample disposal after examination

*) The attending physician confirms by sending the request form that the patient or legal guardian signed the IC, which is either enclosed in patient documentation or attached to this form

Test provides: GENNET, s.r.o., GENNET Laboratories, Pekařská 635/6, 158 00 Praha 5 – Jinonice, Tel: 226 231 691

Lab records:
Date and time of sample receipt: _____ Receipt done by: _____