Request form for cytogenetic/molecular cytogenetic examination

Patient personal data (label)	**Attending physician:**
Name and surname: Insurance number: Date of birth: Insurance: ☐ direct payer Address: ☐ man ☐ woman Diagnosis (MKN):	(name, expertise, ID, workplace, stamp, signature)

Primary sample:

- ☐ peripheral blood (2 ml incoagulable blood in heparin)
- ☐ peripheral blood (5 ml incoagulable blood in EDTA)
- ☐ amniotic fluid
- ☐ chorionic villi
- ☐ cord blood (2 ml incoagulable blood in heparin)
- ☐ cord blood (2 ml incoagulable blood in EDTA)
- ☐ sperm (100 µl)
- ☐ other sample (please specify):

Other material:

- ☐ isolated DNA from:
- ☐ fixed cytogenetic preparation

Date and time of collection:	**Date and time of indication** (when different from collection date):

Clinical data: (provided by attending physician, please use a special form for SNP array) ☐ **STATIM**

Required examinations:

- ☐ karyotype from peripheral blood
- ☐ karyotype from amniotic fluid
- ☐ karyotype from chorionic villi
- ☐ karyotype from cord blood
- ☐ acquired chromosomal aberrations (from peripheral blood)
- ☐ SNP array
- ☐ array CGH
- ☐ *FISH (please specify)*
- ☐ sperm DNA fragmentation (Halosperm)
- ☐ cultivation for further purpose

Informed consent* – the patient agrees with:

- ☐ sample examination
- ☐ use for internal/external quality control
- ☐ requires examination of random findings
- ☐ sample storage in a bank
- ☐ use of sample for research purposes
- ☐ 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

Examination is carried out by: GENNET, s.r.o., GENNET laboratories, Kostelní 9/292, 170 00 Praha 7, tel.:222 313 000

Laboratory records:
Date and time of receipt of sample/form:

Sample/form received by:

Informed consent with cytogenetic/molecular cytogenetic examination

I agree with the examination of my sample in the Center for genetics and reproductive medicine GENNET, s.r.o. (hereinafter Center) for:

- ☐ karyotype from peripheral blood
- ☐ karyotype from amniotic fluid
- ☐ karyotype from chorionic villi
- ☐ karyotype from cord blood
- ☐ acquired chromosomal aberrations
- ☐ SNP array
- ☐ array CGH
- ☐ FISH (please specify)
- ☐ sperm DNA fragmentation (Halosperm)

From tissue sample: peripheral blood, amniotic fluid, chorionic villi, isolated DNA, other type of sample (delete where inapplicable).

I confirm with my signature that I had the opportunity to go through this declaration in detail and ask the physician any related questions.

My questions were clearly answered to my satisfaction. I declare that I have no further questions, I understand the declaration well and agree with the tests, which I certify with my own signature below.

I ask to report the results of the examination
[_] YES [_] NO

I ask to report unexpected findings
[_] YES [_] NO

I agree with preservation of my sample in the bank of the Center for the purpose of possible later follow-up examination depending on the research progress in this field.
[_] YES [_] NO

I agree with possible use of my sample for research purposes [_] YES [_] NO

I agree with possible use of my sample for internal/external quality control [_] YES [_] NO

I require the disposal of my sample after the examination [_] YES [_] NO

Name and surname of the patient:

Insurance number/date of birth:

Date and signature of the patient:

I confirm that I instructed the patient appropriately, as stated above.

Name and surname of the physician:

Date and signature of the physician: .....