

Preimplantation genetic test request form

Preimplantation genetic testing - PGT („Preimplantation Genetic Testing“)

Part 1 - to be filled by the clinician requesting PGT

Personal data of the Patient	Requesting clinician
Name and Surname: Date of birth: Address: Diagnosis (ICD):	(name, specialty, address, stamp, signature)
Type of preimplantation testing:	Indication:
<input type="checkbox"/> PGT for aneuploidies (PGT-A)	<input type="checkbox"/> age <input type="checkbox"/> recurrent miscarriage <input type="checkbox"/> recurrent IVF failure <input type="checkbox"/> other:
PGT – sex selection	Reason:
PGT for chromosomal structural rearrangements (PGT-SR)Kary otype of the carrier:	
PGT for monogenic disorder/single gene defects (PGT-M)	Gene: Inheritance:
<input type="checkbox"/> other:	Description:
Biopsy	
<input type="checkbox"/> blastomere	<input type="checkbox"/> trophectoderm
Time requirements for the results:	
<input type="checkbox"/> standard – in 30 days	<input type="checkbox"/> for transfer in immediate next cycle – in 14 days <input type="checkbox"/> for fresh transfer – in 2 days
Examinations are performed by: GENNET, s.r.o., Kostelní 9/292, Prague, CZ-17000	
Records of the laboratory: Date and time of request form receipt:	Accepted by:

The requesting clinician confirms that the patients have signed Informed consent form that is either stored in their records or is attached to this form and that all legal requirements for PGD/PGS are met.

PGT protocol

Part 2 - to be filled by the embryology lab during blastomere / trophectoderm biopsy

Patient:			
Date of birth:			
Requested test:			
Number of biopsied embryos:			
Day of embryo cultivation at the time of biopsy:			
Biopsy performed by:			
Date of biopsy:		Witnessed by:	
Embryology lab		Genetic lab- GENNET	
Embryo Id	Number of cells / embryo stage	Embryo Id	Result

Date:

Signature:

Witnessed by: