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:**
☐ PGT for aneuploidies (PGT-A)	☐ age ☐ recurrent miscarriage ☐ recurrent IVF failure ☐ 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:
☐ other:	Description:
Biopsy	
☐ blastomere	☐ trophectoderm
Time requirements for the results:	
☐ standard – in 30 days	☐ for transfer in immediate next cycle – in 14 days ☐ 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: