

Preconception genetic examination request for patients

Patient's Personal Data (Label):	Referring Physician:
Name and Surname:	
Insurance Number:	
Date of Birth:	
Insurance Company: Self-payer	
Gender: male female	
Address:	
Diagnosis (ICD):	(Name, Specialization, ICP, Workplace, Stamp, Signature)
Primary Sample: peripheral blood (5 ml non-coagulated blood))	Other Material:
□ in K3EDTA (molecular genetics) Buccal swab (molecular genetics) in Li-Heparin (Karyotype, FISH, ZCA)
isolated (IS) DNA from: (molecular genetics)	Is IS DNA already at the GNTlabs? YES NO with the request form)
Date and Time of Collection:	Date and Time of Indication (if different from collection date):
	,
Clinical Data: (To be completed by the referring physician or atta	nch a clinical report to the request form)
Reasons for Examination (Diagnosis, Indication):	
Primary infertility / ≥2 failed IVF attempts (N97.8) Abnormal sperm cou	(Azoospermia, nt/spermiogram OAT <10M*) (NM6) Congenital defects in Personal History (Z87.7)
Recurrent pregnancy loss (2 or more) (N96) Amenorrhea (N91.	- OAT (10W) (1440)
, , , , , , , , , , , , , , , , , , , ,	in Family History (Z82.7) Other reasons/causes (Z82.7)
Requested Examinations:	
Karyotype FISH	(Specify chromosome and area) ZCA*
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Callel lest - Fleconception Failer (Patient Examination	(thrombophilia profile, recessive mutation carrier status, response to FSH
	(thrombophilia profile, recessive mutation carrier status, response to FSH stimulation, for men Y chromosome microdeletions - AZFa, AZFb, AZFc incl. SRY) illity Report) Will partner sampling be done at the same time? YES NO
Genetic Compatibility Test for the Couple (Compatit	
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