GNT LABS BY GENNET

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 *(We send IS DNA 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 attach a clinical report to the request form) ☐ **STATIM**

Reasons for Examination (Diagnosis, Indication):

☐ Primary infertility / ≥2 failed IVF attempts (N97.8)
☐ Abnormal sperm count/spermiogram (Azoospermia, OAT <10M*) (N46)
☐ Congenital defects in Personal History (Z87.7)
☐ Recurrent pregnancy loss (2 or more) (N96)
☐ Amenorrhea (N91.2)
☐ Consanguinity (Z84.3)
☐ POF (Premature Ovarian Failure) (E28.3)
☐ Congenital defects in Family History (Z82.7)
☐ Other reasons/causes (Z82.7)

Requested Examinations:

☐ **Karyotype** ☐ **FISH** *(Specify chromosome and area)* ☐ **ZCA***

☐ **CarrierTest - Preconception Panel** (Patient Examination) *(thrombophilia profile, recessive mutation carrier status, response to FSH stimulation, for men Y chromosome microdeletions - AZFa, AZFb, AZFc incl. SRY)*

☐ **Genetic Compatibility Test for the Couple** (Compatibility Report) Will partner sampling be done at the same time? ☐ YES ☐ NO

Information about the partner:

Name, Surname: IN or Birth No */Date of Birth:

*IN= insurance number, Birth No = patient ID, *ZCA – gathered chromosomal aberrations

Enter at least one data point

Is your partner a carrier of a gene mutation identified by CarrierTest? *(If yes, fill in below.)*

The partner's mutation is in the genes: *(Please provide the exact name of the gene/genes)*

Separate Molec. Genetic Tests:

☐ **Fragile X syndrome** - Detection of CGG repeat expansion in the ***FMR1*** gene
☐ **Cystic Fibrosis** - 50 mutations + Tn variants of IVS8 ***CFTR***
☐ **Y chromosome microdeletions** - AZFa, AZFb, AZFc incl. *SRY*
☐ **Response to hormonal stimulation** - Ser680Asn polymorphism of the ***FSHR*** gene
☐ **KIR DNA Test** - KIR haplotype determination (A/B)
☐ **HLA-C DNA Test** - HLA-C typing (C1/C2)

Informed Consent* – Subject under examination:

CONSENTS ☑ to sample examination DOES NOT CONSENT ☐ to sample storage

☐ to use of sample for research purposes

☐ to sample storage

*) By sending the request form, the referring physician confirms that the Informed Consent has been signed by the patient or their legal guardian, and is either stored in the patient's documentation or attached to this request form.

Examination performed by: GENNET, s.r.o., GENNET Laboratories, Pekařská 635/6, 158 00 Praha 5 – Jinonice, Phone: 226 231 691

Laboratory Records:

Date and Time of Sample/Request Form Reception: Sample/Request Form Received by: