prePGT-M test requisition form

For Juno Genetics internal use only	Juno Genetics number	Date and time of reception	Received by	Case Status	State the reason for rejection
				☐ Accepted ☐ Rejected	

**The sections marked with (*) are mandatory to fill in to request the test*

REFERRING CLINIC DETAILS			
Referring Clinic *		Referring Clinician *	
Clinician's email *			

FEMALE PATIENT CLINICAL INFORMATION					
Surname/Name *				DOB *	DD/MM/YYYY
Clinic ID *				Gamete donor *	☐ Yes ☐ No
Sample type *	☐ Blood ☐ Saliva/ buccal swab ☐ DNA ☐ Other: _____				
1st	Genetic Disorder *		Gene *		Mutation *
	OMIM#		OMIM#		
	Genetic Status *				
	☐Unaffected	☐Carrier	☐Affected	☐Not tested	
2nd	Genetic Disorder *		Gene *		Mutation *
	OMIM#		OMIM#		
	Genetic Status *				
	☐Unaffected	☐Carrier	☐Affected	☐Not tested	

MALE PATIENT CLINICAL INFORMATION					
Surname/Name *				DOB *	DD/MM/YYYY
Clinic ID *				Gamete donor *	☐ Yes ☐ No
Sample type *	☐ Blood ☐ Saliva/ buccal swab ☐ DNA ☐ Other: _____				
1st	Genetic Disorder *		Gene *		Mutation *
	OMIM#		OMIM#		
	Genetic Status *				
	☐Unaffected	☐Carrier	☐Affected	☐Not tested	
2nd	Genetic Disorder *		Gene *		Mutation *
	OMIM#		OMIM#		
	Genetic Status *				
	☐Unaffected	☐Carrier	☐Affected	☐Not tested	

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CLINICAL INFORMATION OF FAMILY MEMBERS
(if applicable; also, in case of additional family members, reuse this page)

1st family member as reference

Surname/Name *		DOB *	DD/MM/YYYY
Gender *	☐ Male ☐ Female		
Sample type *	☐ Blood ☐ Saliva/ buccal swab ☐ DNA ☐ Other: _____		
Relationship to **pre-embryos** for PGT-M*	☐ Grandparent ☐ Sibling ☐ Uncle/ aunt ☐ Other:_____	Select one or both options: ☐ Maternal affiliation ☐ Paternal affiliation	

1st	Genetic Disorder *		Gene *	Mutation *
	OMIM#		OMIM#	
	Genetic Status *			
	☐Unaffected	☐Carrier	☐Affected	☐Not tested
2nd	Genetic Disorder *		Gene *	Mutation *
	OMIM#		OMIM#	
	Genetic Status *			
	☐Unaffected	☐Carrier	☐Affected	☐Not tested

2nd family member as reference

Surname/Name *		DOB *	DD/MM/YYYY
Gender *	☐ Male ☐ Female		
Sample type *	☐ Blood ☐ Saliva/ buccal ☐ DNA ☐ Other: _____		
Relationship to **pre-embryos** for PGT-M *	☐ Grandparent ☐ Sibling ☐ Uncle/ aunt ☐ Other:_____	Select one or both options: ☐ Maternal affiliation ☐ Paternal affiliation	

1st	Genetic Disorder *		Gene *	Mutation *
	OMIM#		OMIM#	
	Genetic Status *			
	☐Unaffected	☐Carrier	☐Affected	☐Not tested
2nd	Genetic Disorder *		Gene *	Mutation *
	OMIM#		OMIM#	
	Genetic Status *			
	☐Unaffected	☐Carrier	☐Affected	☐Not tested

Health Professional Authorised To Request The prePGT-M TEST

I certify that, to the best of my knowledge, the patients' and clinical information provided in this form are correct. Based on the clinical indication and my professional expertise, I have requested this test for the patient(s). The limitations of the test, including the fact that PGT-M is not 100% accurate and that prenatal testing is needed to confirm the test result in any pregnancy obtained after PGT, have been explained to the patients and all relevant questions have been answered. I agree to provide any additional information requested by Juno Genetics with regard to this particular test.

Authorised referrer Signature *		Date *	DD/MM/YYYY

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