Test Requisition Form
prePGT-M

Don't write in this grey area. For Juno Genetics internal use only	Juno Genetics number	Date received	Received by

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

REFERRING CLINIC DETAILS

Name of referring clinician*		Referring Clinic*	
Clinician Email*			

FEMALE PATIENT INFORMATION

Patient name*		Patient date of birth*	DD/MM/YYYY
Patient clinic ID *		Gamete donor*	☐ Yes ☐ No
Sample type*	☐ Blood ☐ Saliva/ buccal swab ☐ DNA ☐ Other _____		

CLINICAL INFORMATION

Genetic disorder*:				OMIM#
Gene*	OMIM#*	Variant*	Inheritance pattern*	Zygosity*
			Choose an item	☐ Heterozygous ☐ Negative ☐ Hemizygous ☐ Not tested ☐ Homozygous
2nd Genetic disorder* (if applicable):				OMIM#
Gene*	OMIM#*	Variant*	Inheritance pattern*	Zygosity*
			Choose an item	☐ Heterozygous ☐ Negative ☐ Hemizygous ☐ Not tested ☐ Homozygous

MALE PATIENT INFORMATION

Patient name*		Patient date of birth*	DD/MM/YYYY
Patient clinic ID *		Gamete donor*	☐ Yes ☐ No
Sample type*	☐ Blood ☐ Saliva/ buccal swab ☐ DNA ☐ Other _____		

CLINICAL INFORMATION

Genetic disorder*:				OMIM#
Gene*	OMIM#*	Variant*	Inheritance pattern*	Zygosity*
			Choose an item	☐ Heterozygous ☐ Negative ☐ Hemizygous ☐ Not tested ☐ Homozygous
2nd Genetic disorder* (if applicable):				OMIM#
Gene*	OMIM#*	Variant*	Inheritance pattern*	Zygosity*
			Choose an item	☐ Heterozygous ☐ Negative ☐ Hemizygous ☐ Not tested ☐ Homozygous

DONOR INFORMATION (if applicable)

Donor ID*		Donor date of birth*	DD/MM/YYYY
Sample type*	☐ Blood ☐ Saliva/ buccal swab ☐ DNA	Gamete donor*	☐ Egg ☐ Sperm

CLINICAL INFORMATION

Genetic disorder*:				OMIM#
Gene*	OMIM#*	Variant*	Inheritance pattern*	Zygosity*
			Choose an item	☐ Heterozygous ☐ Negative ☐ Hemizygous ☐ Not tested ☐ Homozygous

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Test Requisition Form
prePGT-M

REFERENCE INFORMATION
(if applicable; also, in case of additional family members, reuse this page)

1st family member as reference

Patient name*		Patient date of birth*	DD/MM/YYYY
Gender*	☐ Male ☐ Female	Sample type*	☐ Blood ☐ Saliva/ buccal swab ☐ DNA ☐ Other _____
Relationship to pre-embryos for PGT-M**	☐ Grandparent ☐ Sibling	Affiliation*	☐ Maternal affiliation ☐ Paternal affiliation

CLINICAL INFORMATION

Genetic disorder*:				OMIM#
Gene*	OMIM#*	Variant*	Inheritance pattern*	Zygosity*
			Choose an item	☐ Heterozygous ☐ Negative ☐ Hemizygous ☐ Not tested ☐ Homozygous
2nd Genetic disorder* (if applicable):				OMIM#
Gene*	OMIM#*	Variant*	Inheritance pattern*	Zygosity*
			Choose an item	☐ Heterozygous ☐ Negative ☐ Hemizygous ☐ Not tested ☐ Homozygous

2nd family member as reference

Patient name*		Patient date of birth*	DD/MM/YYYY
Gender*	☐ Male ☐ Female	Sample type*	☐ Blood ☐ Saliva/ buccal swab ☐ DNA ☐ Other _____
Relationship to pre-embryos for PGT-M**	☐ Grandparent ☐ Sibling	Affiliation*	☐ Maternal affiliation ☐ Paternal affiliation

CLINICAL INFORMATION

Genetic disorder*:				OMIM#
Gene*	OMIM#*	Variant*	Inheritance pattern*	Zygosity*
			Choose an item	☐ Heterozygous ☐ Negative ☐ Hemizygous ☐ Not tested ☐ Homozygous
2nd Genetic disorder* (if applicable):				OMIM#
Gene*	OMIM#*	Variant*	Inheritance pattern*	Zygosity*
			Choose an item	☐ Heterozygous ☐ Negative ☐ Hemizygous ☐ Not tested ☐ Homozygous

HEALTH PROFESSIONAL

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.

Signature of authorised healthcare professional*		Date of request*	DD/MM/YYYY

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