

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

*\*The sections marked with (\*) are mandatory to fill in to request the test  
\*\*In addition, in case of further samples, reuse this form*

### TEST TYPE which the sample(s) are related to:

PGT-M       PGT-A Incidental Findings       PGT-SR Incidental Findings       Other: \_\_\_\_\_

### REFERRING CLINIC DETAILS

Name of referring clinician\* \_\_\_\_\_ Referring Clinic\* \_\_\_\_\_  
Clinician Email\* \_\_\_\_\_

### SAMPLE 1

Patient name*		Patient date of birth*	DD/MM/YYYY
Patient clinic ID*		Gamete donor*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex*	<input type="checkbox"/> Male <input type="checkbox"/> Female	Sample collection date*	
Relationship to <u>pre-embryos</u> for PGT**	<input type="checkbox"/> Mother/Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Other _____	Affiliation*	<input type="checkbox"/> Maternal affiliation <input type="checkbox"/> Paternal affiliation
Sample type*	<input type="checkbox"/> Blood <input type="checkbox"/> Saliva/ buccal swab <input type="checkbox"/> DNA <input type="checkbox"/> Other _____		

### SAMPLE 2

Patient name*		Patient date of birth*	DD/MM/YYYY
Patient clinic ID*		Gamete donor*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex*	<input type="checkbox"/> Male <input type="checkbox"/> Female	Sample collection date*	
Relationship to <u>pre-embryos</u> for PGT**	<input type="checkbox"/> Mother/Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Other _____	Affiliation*	<input type="checkbox"/> Maternal affiliation <input type="checkbox"/> Paternal affiliation
Sample type*	<input type="checkbox"/> Blood <input type="checkbox"/> Saliva/ buccal swab <input type="checkbox"/> DNA <input type="checkbox"/> Other _____		

### SAMPLE 3

Patient name*		Patient date of birth*	DD/MM/YYYY
Patient clinic ID*		Gamete donor*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex*	<input type="checkbox"/> Male <input type="checkbox"/> Female	Sample collection date*	
Relationship to <u>pre-embryos</u> for PGT**	<input type="checkbox"/> Mother/Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Other _____	Affiliation*	<input type="checkbox"/> Maternal affiliation <input type="checkbox"/> Paternal affiliation
Sample type*	<input type="checkbox"/> Blood <input type="checkbox"/> Saliva/ buccal swab <input type="checkbox"/> DNA <input type="checkbox"/> Other _____		

### SAMPLE 4

Patient name*		Patient date of birth*	DD/MM/YYYY
Patient clinic ID*		Gamete donor*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex*	<input type="checkbox"/> Male <input type="checkbox"/> Female	Sample collection date*	
Relationship to <u>pre-embryos</u> for PGT**	<input type="checkbox"/> Mother/Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Other _____	Affiliation*	<input type="checkbox"/> Maternal affiliation <input type="checkbox"/> Paternal affiliation
Sample type*	<input type="checkbox"/> Blood <input type="checkbox"/> Saliva/ buccal swab <input type="checkbox"/> DNA <input type="checkbox"/> Other _____		