Sample collection form
PGT

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*
***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*	☐ Yes ☐ No
Sex*	☐ Male ☐ Female	Sample collection date*	
Relationship to pre-embryos for PGT**	☐ Mother/Father ☐ Sibling ☐ Grandparent ☐ Other _____	Affiliation*	☐ Maternal affiliation ☐ Paternal affiliation
Sample type*	☐ Blood ☐ Saliva/ buccal swab ☐ DNA ☐ Other _____		

SAMPLE 2

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

SAMPLE 3

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

SAMPLE 4

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

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JUNO GENETICS SPAIN, S.L.
Ronda de Guglielmo Marconi, 11-A, 2º, A1-2, A2-2.
46980 Paterna Valencia.
supportspain@junogenetics.com