

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 DETA	AILS			
Refe	rring Clinic *							
Clinic	cian's email *					-		
		FI	EMALE PATIENT CLI	NICAL INFO	ORMATION			
Surna	ame/Name *					DD/MM/YYYY		
Patie	nt clinic ID *				Gamete dor	nor *		
Sample type *		☐ Blood	☐ Saliva/ buccal s		□ DNA	☐ Other:		
	Geneti	: Disorder *		Gene *		Mutation *		
	ON AUN AU		ONAINA#					
1 st	OMIM#			OMIM# Genetic Status *				
		□Unaffected	☐ Carrier		Affected	□ Not tested		
	Genetio	: Disorder *		Gene *		Mutation *		
2 nd	OMIM#		OMIM#					
		_		etic Status *				
		□Unaffected	□Carrier		Affected	□ Not tested		
	/a.a. str		MALE PATIENT CLIN	IICAL INFO				
	Surname/Name *				DOB *	DD/MM/YYYY		
	nt clinic ID *				Gamete dor ☐ DNA			
Samp	ole type *	□ Blood	☐ Saliva/ buccal s	· · · · · · · · · · · · · · · · · · ·		Other:		
	Genetic	: Disorder *		Gene *		Mutation *		
.ct	OMIM#		OMIM#					
1 st	•		Gen	etic Status *	•			
		□Unaffected	□Carrier		Affected	☐ Not tested		
	Genetic Disorder *			Gene *		Mutation *		
2 nd	OMIM#		OMIM#					
2	Civilivim			etic Status *				
		Unaffected	□Carrier			☐ Not tested		
DONOR CLINICAL INFORMATION (if applicable)								
Donor ID *					DOB	DD/MM/YYYY		
Sample type * ☐ Blood ☐ Saliv		☐ Saliva/ buccal swab	va/ buccal swab □ DNA Gamete d		onor * ☐ Egg ☐ Sperm			
-	Genetic	Disorder *		Gene *		Mutation *		
	OMIM#		ONAIN4#					
1 st	Olvilivi#		OMIM#	etic Status *				
_								
•	Г	Unaffected	□Carrier		Affected	☐ Not tested		



prePGT-M test requisition form

CLINICAL INFORMATION OF FAMILY MEMBERS											
(if applicable; also, in case of additional family members, reuse this page) 1st family member as reference											
	Surname/Name *							DO	OB *	DD/MM/YYYY	
Gende	er *		□Ма	ale 🗆	Female						
	le type *		□Blo		Saliva/ b	uccal sv	vab	□ DNA □ Other:			
	onship to	☐ Grand	-	t				Select one or both options:			
pre-e	mbryos for ∕I*	☐ Siblin ☐ Uncle	_					☐ Maternal affiliation			
	' !	☐ Office						☐ Paternal affiliation			
	Genetic Disorder *		•		Gene	*		Mutation *			
1 st	OMIM#			OMIM#							
					Genetic						
	Cono	Unaffected		□Carrier	Gene		☐Affected	□ Not tested Mutation *			
	Gene	etic Disorder *			Gene				IVIU	tation "	
2 nd	OMIM#			OMIM#							
2	Olvinivin	Genetic Status *									
		□Unaffected					☐Affected	□ Not tested			
2 nd fa	amily memb	er as referenc	е								
Surna	me/Name *							DO	OB *	DD/MM/YYYY	
Gende	er*		□Ма	ale [☐ Female						
	le type *		□Blc		□ Saliva/	buccal		DNA		Other:	
	Relationship to $\hfill \Box$ Grandparen			:			Select one or both options:				
pre-e	mbryos for 4 *	☐ Siblin	_			☐ Maternal affiliation					
1 01-1	v1	☐ Uncle ☐ Othe				☐ Paternal affiliation					
	Gene	tic Disorder *	•	Gene *			Mutation *				
	Genetic bisorder			Gene			Widtati	OII			
1 st	OMIM#	1IM#			OMIM#						
		Genetic Status *									
	□Unaffected			☐ Carrier ☐ Affected			□ Not tested				
	Genetic Disorder *			Gene *			Mutation *				
and	ON ALD ALL			OMIM#							
2 nd	OMIM#			Olvilivi#	Genetic	Status *	k				
	□ Unaffected □ Carri					enetic Status *			□Not te	ested	
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 Date * DD/MM/Y///							D/MM/YYYY				
Signature *											