TEST REQUISITION FORM

Setgene Lab
Centre For Human Genetics

PREIMPLANTATION GENETIC TESTING

PATIENT DETAILS: (In BLOCK letters)

Full Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

BOD: ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)   Age: ☐☐ / ☐☐ (YY/MM)   Gender: ☐ M ☐ F   Ethnicity ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Partner's Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐   BOD: ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) or Age: ☐☐ / ☐☐ (YY/MM)

E-mail ID: _____   Contact No.: ☐☐☐☐☐☐☐☐☐☐☐

Height: ☐☐☐ cm   Weight: ☐☐☐ kg   Blood Type: ☐☐☐

Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

REFERRING CLINICIAN: (In BLOCK letters)

Clinician Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Embryologist Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Hospital/ Clinic Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

E-mail ID*: _____   Contact No.: ☐☐☐☐☐☐☐☐☐☐

E-mail ID of Contact Person* _____   Contact No.: ☐☐☐☐☐☐☐☐☐☐

*Note: Report will be sent to both Emails

SAMPLE DETAILS:

☐ EDTA Blood (For Pre-PGT-M work up; 4ml)   ☐ Couple   ☐ Affected Inndividual

☐ Embryos   No of embryos _____   Day of biopsy

Donor: ☐ Yes ☐ No   If yes ☐ Donor Egg ☐ Donor Sperm

Age of the Donor: _____

Rebiopsy: ☐ Yes ☐ No   If yes, please provide previous ID of the patient: _____

CYCLE HISTORY:

Hyperstimulation: ☐ Yes ☐ No   Fertilisation method: ☐ IVF ☐ ICSI

Date of egg retrieval: _____ / _____ / _____   No. of embryos retrieved: _____

No. of biopsied embryos: _____

*Date/Time planned for embryo transfer: _____ / _____ / _____

TEST REQUISITION FORM

TEST REQUESTED: _____

- ☐ **Preimplantation genetic testing for aneuploidies (PGT-A)**
- ☐ **Preimplantation genetic testing for structural rearrangements (PGT-SR)** (attach parental karyotype report)
- ☐ **Preimplantation genetic testing for monogenic disorders (PGT-M)*** (Requested for Gene.....................................Variant....................................)
  (* Please mention Pre-PGT-M Lab ID..................................)
- ☐ **Pre-PGT Work up** (Mandatory to do before PGT-M, Sample type- 4ml EDTA blood) Attach relevant genetic reports / Hb electrophoresis report.

In case of PGT-A
Is Karyotype done for the couple-   ☐ **Yes** (If yes, kindly provide the reports)   ☐ **No**

In case of PGT-SR
Kindly provide parental karyotype reports prior to testing.

In case of PGT-M
Kindly contact NCGM and discuss with the Clinical Geneticist/ Genetic Counsellors regarding the utility of PGT-M for the suspected condition/ reported genetic variant/s.

Indication for the test
- ☐ **Recurrent Pregnancy loss**
- ☐ **Advanced maternal age**
- ☐ **IVF Failure**
- ☐ **Primary Infertility**
- ☐ **BOH**
- ☐ **Others** _____

Indication for the test
NGS-based PGT-A is able to detect embryo mosaicism. NCGM reports an embryo as "Low mosaic" or "High mosaic". We recommend that all patients with mosaic embryos seek genetic counseling prior to considering transfer. Please indicate your preference regarding the reporting of mosaic embryos:

- ☐ **Yes - indicate embryo mosaicism on PGT-A report**   ☐ **No - designate mosaic embryos as aneuploid**
- ☐ **Do not report mosaicism**

Embryo Details:

Tube No	Sample ID	No. of Cell(s)	Grade of Cells	Comments	Type of Cells