

Request form for genetic examination - CarrierTest

PATIENT INFORMATION	REPORTING RECIPIENTS
Name and surname: Insurance number: Date of birth: Insurance: direct payer man woman Address: Diagnosis (MKN):	Ordering physician: <hr/> Institution name: <hr/> Phone: <hr/> Email: <hr/>
Primary sample:	Sampling date/time:
Perrifer blood in K ₃ EDTA	
Clinical data:	
Egg / Sperm Donor Consanguinity	Male Infertility / Female Infertility Family history
Details:	
<p>CarrierTest - pre-conception panel (trombosis Profile, Carrier of recessive mutations, response to FSH stimulation)</p> <p>CarrierTest compatibility with partners</p> <p>Partner's name: _____ Partner's Date of Birth: _____</p> <p>Samples from both partners will be provided simultaneously.</p>	
Informed consent* – the patient:	
AGREE with sample examination use for internal/external quality control requires examination of Incidental findings	DISAGREE requires sample disposal after examination
<p><small>*) The attending physician confirms by sending the request form that the patient or legal guardian signed the IC, which is either enclosed in patient documentation or attached to this form</small></p>	
Examination conducted by: GENNET, s.r.o., GENNET Laboratories, Pekařská 635/6, 158 00 Praha 5 – Jinonice, Tel: 226 231 691	
Laboratory records:	
Date and time of sample/request receipt:	Sample/request received by:

