

Request form for genetic examination of gamete donors

Personal data of the examined person (label):	Referring physician:
Name and surname: Insurance number: Date of birth: Insurance company: self-payer Gender: male female Address: Diagnosis (ICD):	(Name, specialty, establishment ID number, workplace, stamp,
Diagnosis (IOD).	signature)
Primary sample: peripheral blood (5 ml non-coagulated)	Other material:
In K ₃ EDTA (molecular genetics)	DNA isolated from: (molecular genetics)
In Li-Heparin (cytogenetics)	
Date and time of collection:	Date and time of indication (if different from the collection date):
Clinical data: (to be completed by the referring physician or attached as a clinical report to the request)	
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Requested tests:	
Cytogenetics	
Karyotype	
Molecular genetics	
Cystic fibrosis (50 common mutations + Tn variants of IVS8 gene <i>CFTR</i>)	
Carrier screening panel for gamete donor candidate	
FRAXA syndrome - Examination of triplet (CGG) repeat expansion in the FMR1 promoter	
Informed consent* - examined person:	
AGREES with the examination of the sample	DISAGREES with sample storage
with the use of the sample for resear	rch
with sample storage	
*) By submitting the request, the referring physician confirms that the patient or legal representative has signed the Informed Consent, which is either stored in the patient's documentation or attached to this request.	
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:

