GNT LABS BY GENNET

Request form for cytogenetic/molecular genetic examination

Patient personal data (label)	**Attending physician:**
Name and surname: Insurance number: Date of birth: Insurance: ☐ direct payer ☐ man ☐ woman Address: Diagnosis (MKN):	(name, expertise, ID, workplace, stamp, signature)

Primary sample:	**Other material:**
☑ peripheral blood (5 ml incoagulable blood in heparin)	☒ isolated DNA from:
☒ peripheral blood (5 ml incoagulable blood in EDTA)	☒ fixed cytogenetic preparation
☒ amniotic fluid	
☒ chorionic villi	
☒ cord blood (2 ml incoagulable blood in heparin)	
☒ cord blood (2 ml incoagulable blood in EDTA)	
☒ sperm (100 µl)	
☒ other sample (please specify):	

Date and time of collection:	**Date and time of indication** (when different from collection date):

Clinical data: (provided by attending physician, please use a special form for SNP array) ☑ **STATIM**

Required examinations:

☑ karyotype from peripheral blood	☒ SNP array
☒ karyotype from amniotic fluid	☒ array CGH
☒ karyotype from chorionic villi	☒ *FISH (please specify)*
☒ karyotype from cord blood	☒ sperm DNA fragmentation (Halosperm)
☒ acquired chromosomal aberrations (from peripheral blood	☒ cultivation for further purpose

Informed consent*- the patient:

AGREE WITH ☐ sample examination ☐ use for research ☐ sample storage

DISAGREE WITH ☐ sample storage

*) Requesting clinical confirms by sending this request form that the patient pr legal representative has signed an informed consent, which is either part of patient´s documentation or is attached to this request form

Examination performed 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 receipt of the sample/request form: Signature: