Neuberg DIAGNOSTICS | CENTER FOR GENOMIC MEDICINE

TEST REQUISITION FORM

PREIMPLANTATION GENETIC TESTING

TEST REQUESTED

☐ **Pre-PGT-M** (Mandatory to do before PGT-M, Sample type- 4ml EDTA blood) Attach relevant genetic reports/ Hb electrophoresis report.

☐ **Preimplantation genetic testing for monogenic disorders (PGT-M)*** (Requested for Gene_____Variant_____)
(* Please mention Pre-PGT-M Lab ID_____)

☐ **Preimplantation genetic testing for aneuploidies (PGT-A)**

☐ **Preimplantation genetic testing for structural rearrangements (PGT-SR)** (attach parental karyotype report)

In case of PGT-A

Is Karyotype done for the couple- ☐ **Yes**(If yes, kindly provide the reports) ☐ **No**

Reason for the test

☐ Recurrent Pregnancy loss ☐ Advanced maternal age ☐ IVF Failure ☐ Primary Infertility ☐ BOH

☐ Others_____

Reporting of Mosaics

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

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.

In case of PGT-SR

Kindly provide parental karyotype reports prior to testing.

PATIENT DETAILS

(In BLOCK letters)

Patient Name

DOB (D D / M M / Y Y Y Y) or Age (Y Y / M M) Ethnicity

Partner's Name DOB (D D / M M / Y Y Y Y) or Age (Y Y / M M)

E-mail ID Contact No.

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

Address

Neuberg Centre for Genomic Medicine (NCGM)
Near GTPL House, Opp. Armedia, Sindhu Bhavan Road, Bodakdev, Ahmedabad 380059
Phone: +91-6357244307, 079-61618111 | Email: contact@ncgmglobal.com | Web: www.ncgmglobal.com

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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
(In BLOCK letters)

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

☐ 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
(In BLOCK letters)

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: _____/_____/_____

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Embryo details:

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

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