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TEST REQUISITION FORM

Carrier Screening / Infertility-related Testing

Requisitioner details

Medical Center / Health Facility | Service/Department | Date

First Name | Family Name | E-mail

Address | City

Province/State | Postal Code | Country | Phone

Patient/Donor details

First Name | Family Name | Gender

Birthdate | Medical Record no. | E-mail

Province/State | Postal Code | Phone

Sample information

Sample type | Extraction method | Extraction date

Remarks

Requested testing (please tick appropriate boxes):

- ☐ Karyotype ●
- ☐ Cystic fibrosis (CFTR 50 frequent mutations) ●
- ☐ Spinal muscular atrophy (SMN1 deletion) ●
- ☐ Fragile-X ●
- ☐ Carrier Screening 298-genes **for egg donors** (32-genes subset reported) ●
- ☐ Carrier Screening 298-genes **for sperm donors** (12-genes subset reported) ●
- ☐ Carrier Screening 298-genes **for patients** (all genes reported - matchings upon request) ●
- ☐ KIR / HLA-C genotyping ●
- ☐ Y chromosome microdeletions (AZF region) ●
- ☐ Sperm FISH analysis (5 chromosomes) ●
- ☐ Thrombophilia Panel (Factor II G20210A; Factor V Leiden G1691A; MTHFR C677T and A1298C) ●

Required sample: ● Lithium heparin tube (green top) ● EDTA tube (purple top) ● Standard plastic flask