PGT-related sample collection form

TEST TYPE which the sample(s) are related to :	
☐ PGT-M	☐ PGT-A
☐ PGT-SR	☐ Paternity testing
☐ Other: _____	

REFERRING CLINIC DETAILS	
Clinic name	
Referring clinician	
Contact email	

Fill in the following details for each sample sent (one for each patient if multiple samples sent together):

PATIENT 1 DETAILS			
Full Name		Date of birth	
Clinic ID		Gamete donor	☐ Yes ☐ No
Sex	◯ Male ◯ Female	Sample collection date	
Sample type	◯ Blood ◯ Saliva/ buccal ◯ DNA ◯ Other:_____		
Relationship to **pre-embryos** for PGT	◯ Mother ◯ Maternal grandparent (parent of the female IVF patient) ◯ Father ◯ Paternal grandparent (parent of the male IVF patient) ◯ Sibling (IVF couple's previous child) ◯ Uncle/ aunt (brother/sister of the couple) ◯ Other:_____		

PATIENT 2 DETAILS (if applicable)			
Full Name		Date of birth	
Clinic ID		Gamete donor	☐ Yes ☐ No
Sex	◯ Male ◯ Female	Sample collection date	
Sample type	◯ Blood ◯ Saliva/ buccal ◯ DNA ◯ Other:_____		
Relationship to **pre-embryos** for PGT	◯ Mother ◯ Maternal grandparent (parent of the female IVF patient) ◯ Father ◯ Paternal grandparent (parent of the male IVF patient) ◯ Sibling (IVF couple's previous child) ◯ Uncle/ aunt (brother/sister of the couple) ◯ Other:_____		

PATIENT 3 DETAILS (if applicable)			
Full Name		Date of birth	
Clinic ID		Gamete donor	☐ Yes ☐ No
Sex	◯ Male ◯ Female	Sample collection date	
Sample type	◯ Blood ◯ Saliva/ buccal ◯ DNA ◯ Other:_____		
Relationship to **pre-embryos** for PGT	◯ Mother ◯ Maternal grandparent (parent of the female IVF patient) ◯ Father ◯ Paternal grandparent (parent of the male IVF patient) ◯ Sibling (IVF couple's previous child) ◯ Uncle/ aunt (brother/sister of the couple) ◯ Other:_____		

For Juno Genetics internal use only	
Date and time of receipt	Received by
Juno procedure No. (for Juno internal use only)	

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