

Patient Information form for Preimplantation Genetic Diagnosis pre-clinical work up

Patient : Last _____ First _____
By Convention, the Woman

Date of Birth 19 ____ ____ ____ Genetically Affected; "Carrier"; "Non carrier"
Year Month Day (Has Gene Mutation) (Heterozygote) (No Gene Mutation)

Patient : Last _____ First _____
The Male Partner

Date of Birth 19 ____ ____ ____ Genetically Affected; "Carrier"; "Non carrier"
Year Month Day (Has Gene Mutation) (Heterozygote) (No Gene Mutation)

Affected Relative: Last _____ First _____
If Any

Date of Birth ____ ____ ____ Relationship to Patient _____
Year Month Day (Son, Sister, Mother, Aunt, Nephew, with this Genetic Disorder)

Affected Relative: Last _____ First _____
If Any

Date of Birth ____ ____ ____ Relationship to Patient _____
Year Month Day (Son, Sister, Mother, Aunt, Nephew, with this Genetic Disorder)

Unaffected Relative: Last _____ First _____
If Any

Date of Birth ____ ____ ____ Relationship to Patient _____
Year Month Day (Son, Sister, Mother, Aunt, Nephew, with this Genetic Disorder)

Unaffected Relative: Last _____ First _____
If Any

Date of Birth ____ ____ ____ Relationship to Patient _____
Year Month Day (Son, Sister, Mother, Aunt, Nephew, with this Genetic Disorder)

Genetic Disorder of Concern: _____
(e.g. Cystic Fibrosis, Fragile X)

Indication for PGD: _____
(e.g. Cystic Fibrosis, Fragile X, Beta Thalassaemia combined with HLA matching)

Other Indication: _____
(e.g. Advanced maternal age, recurrent miscarriages, repeated implantation failure, PGS, Chromosomal Translocation)

Case Summary: _____
(Brief description of the case)

Pedigree:

Request:

- | | |
|---|--|
| <input type="checkbox"/> Mutation(s) screening | <input type="checkbox"/> PGD Set Up (single gene defect) |
| <input type="checkbox"/> PGD Set Up (HLA matching) | <input type="checkbox"/> PGD Set Up (Aneuploidy screening) |
| <input type="checkbox"/> PGD Set Up (Translocation) | <input type="checkbox"/> Other (please specify) |
-

Clinic Name: _____

Address: _____

PGD Coordinator with whom we can communicate: _____

Phone: _____
(Or Work Mobile)

Fax: _____

Best Email: _____
VERY important for us to interact with you and coordinate your case

Please fax this form and the DNA diagnostic report(s) that define the gene mutation (if you have it) to us at +390664492025 or e-mail it to the following address: Biricik@laboratoriogenoma.it Call us at +39068811270 if you have any questions.

Date: _____