REQUEST FORM POSTNATAL-CYTOGENETICS

SAMPLE INFORMATION		LNS BARCODE LABEL
Your sample identification Your ID Label	**Sample type / quantity:** ☐ Tissue biopsy: ..... ☐ Peripheral Blood: ..... ☐ Other: ..... **Date / Time of sampling:** ...../...../..... ..... H	LNS label

LABORATOIRE NATIONAL DE SANTE
NATIONAL CENTER OF GENETICS

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ncg-cytogen@lns.etat.lu
Forms available at www.lns.lu

PHYSICIAN REQUESTING THE TEST

Surname and first name of the doctor requesting the test

Address and country

Telephone / direct line

Fax

Date of request

Signature / Stamp

PATIENT INFORMATION

Birth name

First name

Married name

Sex

Date of birth

National identification number

Partner information

Address and country

Patient covered by the CNS ☐ Yes ☐ No

*If not covered by the CNS, the patient will receive an invoice from the laboratory, which they may pass on to their insurance company, where applicable.

Copies to [Please note that results are returned only to the prescriber of the test, who is the only one authorized to give them to patients.]

PREANALYTICAL CONDITIONS

Karyogram and FISH	**7 ml heparinized blood for adult** **5 ml heparinized blood for child** **1-2 ml heparinized blood for newborn**	 (green tube: Heparin, transfer at 4° in 24h)

***Tissue Biopsy (specify sample):**
(sample in a sterilized container, transfer in 24h)

CLINICAL INDICATION

☐ **Reproduction problems:**
☐ *Infertility*
☐ *Karyotype before ART (Assisted Reproduction Technology)*
☐ *Abnormal spermogram :OATS/Oligospermia/Azoospermia/sterility*
☐ *Implantation failures AND nulliparous with history of miscarriages*
☐ *Premature ovarian failure and related clinical presentation*
☐ **Unexplained miscarriages:**
Numbers: ..... *Terms:* ..... *Partner name:* .....
☐ **Autosomal trisomy**
☐ **Turner syndrome/ clinical presentation:**
☐ **Klinefelter syndrome**
☐ **Ambiguous genitalia/clinical presentation:**
☐ **Family history of chromosomal abnormality,**
Please specify: .....
☐ **Proband or parent of proband with abnormal karyotype/CMA result:**
Name of proband: .....
Mother's name of fetus: .....
Karyotype/ CMA result or report number: .....
☐ **Suspected syndrome/mosaicism** specify:
☐ **Gender dysphoria**
☐ **Egg/Sperm freezing/donation**
☐ **Others, please specify:**

ANALYSIS REQUESTED

Conventional cytogenetics

☐ **KARYOGRAM (microscopic banding analysis)** ☐ **FISH based on indication**

☐ **Other constitutional analyses based on indication and/or karyotype finding**

OTHER CLINICAL COMMENTS / SINGLE REQUESTS:

The LNS processes the data collected for the performance of analyses and the transmission of results. To find out more about the management of personal data and to exercise your rights, please refer to the data protection policy on the LNS website at the following address: https://lns.lu/donnees-personnelles/

CONSENT FORM

By signing below, I consent to the genetic testing as indicated on the test request form in order to determine the genetic cause of the above-mentioned clinical condition.
I hereby confirm, that the requesting physician (signed below) has informed me in detail about the medical necessity, potential benefits and limitations of the planned genetic testing. In addition, possible consequences from the communication of the test result (e.g. psychological burden) were discussed.

With your consent, **unused sample material** will be stored. Please decide if and how unused sample material may be used. I consent to the use of this material - for verifying the obtained results, laboratory quality assurance and future diagnostic investigations. - for the purposes of academic teaching and scientific research.	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
I consent being informed[1] of **secondary/additional findings[2]** if these have direct medical implications (e.g. possible prophylactic measures or therapeutic consequences) or may constitute a significant genetic risk for me or my family members. [1] According to current scientific understanding and based on the present recommendations of the American College of Medical Genetics and Genomics (ACMG). [2] Variants that may be obtained incidentally during the course of genetic testing and are associated with a condition other than the one for which testing was originally indicated.	☐ **Yes** ☐ **No**
If necessary, I consent that my sample material, my personal data and the test request is **forwarded** to a specialized cooperating laboratory or institute in order to investigate the above-stated condition in question.	☐ **Yes** ☐ **No**
I consent that data and test results collected in the context of the condition in question may be used in de-identified (pseudonymized) form for **scientific research**[1] and published in anonymized form in medical journals. [1] e.g. to improve the understanding of the molecular pathogenesis and develop new diagnostic or treatment possibilities)	☐ **Yes** ☐ **No**

I am aware that my consent applies to me and/or to my minor child(ren) and I may withdraw this consent at any time, verbally or in writing, without giving reasons.

Signature of requesting physician _____

Place and date:_____

Signature of patient or legal representative(s) _____

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