Department of Obstetrics and Gynaecology

PGD Lab, 4/F, Old Block (K Wing), Prince of Wales Hospital,
The Chinese University of Hong Kong
Shatin, N.T., Hong Kong, SAR
Tel: (852) 3505 1557 | Fax: (852) 3505 4810 | www.obg.cuhk.edu.hk

Name: _____ (Surname) _____ (Name)

Sex: ☐ Female ☐ Male

Sample collection date & time: _____ (DD/ MM/YYYY) _____ (Time)

Chinese Name: _____

Date of birth: ____ / ____ / ____ (DD / MM / YYYY)

Ethnicity:
☐ East Asian (Chinese, Japanese,...)
☐ Southeast Asian (Filipino,...)
☐ South Asian (Indian, Pakistani,...)
☐ Caucasian
☐ African American
☐ Mediterranean
☐ Other:_____

Referral Hospital/ Clinic: _____

Tel: _____

Fax: _____

Patient Label

HKID: _____ ( )

Hospital/
Clinic no.: _____

Referral doctor: _____

Signature: _____

Fees paid by: ☐ Patient ☐ Referral doctor ☐ HA

Clinical history

Previous study
☐ Yes: Lab no.:

Gestational age: ____ wks ____ days (EDC Date: _____) G___ P ___

☐ Advanced maternal age ☐ Translocation carrier: ☐ Previous child/ pregnancy with chr abn: _____

☐ Recurrent abortion ☐ Miscarriage ☐ Familial chr. abn.: _____ ☐ Others: _____

☐ Fetal anomalies (pls specify): _____

☐ Positive Down screening: Risk: _____ ☐ Non-invasive prenatal screening: _____

Specimen type

☐ Amniotic fluid ☐ Chorionic villi ☐ Products of gestation
☐ Placental tissues ☐ Others: _____

Fetal Blood (☐ EDTA ☐Heparin@)

Cord Blood (☐ EDTA ☐Heparin@)

Peripheral Blood (☐ EDTA ☐Heparin@)
(☐ Maternal EDTA*)
(☐ Paternal EDTA*)

Test requested

☐ Karyotyping ☐ QF-PCR for chr. 13,18,21,X &Y ☐ Fragile X PCR assay
FetalSeq$ (☐ Single case ☐ Trio*) ☐ CMA*:Fetal DNA Chip v2.0$
ChromoSeq$ (☐ Single case ☐ Couple ☐ Trio*)
ChromoSeq+Limited Karyotyping#$@ (☐ Single case ☐ Couple ☐ Trio*)
Expanded Carrier screening$ (☐ CUHK 302 genes panel ☐ Comprehensive)
FetalExome$ (☐ Single case ☐ Trio*)

☐ UPD* chr: ____ ☐ PCR for Y chr. microdeletion
☐ FISH: _____ ☐ PCR for 22q11.2 microdeletion
☐ α- and β-thal common mutation screening (5 α+16 β)
☐ α- and β-thal comprehensive testing by LRS
☐ Other test$: _____

***** Proband with the parental samples together
$ Please also attach relevant consent form
# Limited Karyotyping: Only five cells analyzed
@ Heparin Blood for Karyotyping testing only

Spouse's Information
Name:
ID:
DOB:

Remarks: _____

This part for PGD Laboratory use only

Test request form (PD-L0701-F01/V03) Effective date 01 Jul 2025

Specimen Received (Date & Time) _____

Parental EDTA Blood Received
☐ Maternal:
☐ Paternal:

Laboratory no.: _____

PGD Laboratory Use

Department of Obstetrics and Gynaecology

PGD Lab, 4/F, Old Block (K Wing), Prince of Wales Hospital,
The Chinese University of Hong Kong
Shatin, N.T., Hong Kong, SAR

Tel: (852) 3505 1557 | Fax: (852) 3505 4810 | www.obg.cuhk.edu.hk

GENERAL CONSENT FORM
同意書

Patient or Guardian
病人或監護人

* I consent / do not consent to be tested for genetic test/tests which have been explained to me
* 本人同意 / 不同意進行已向本人解釋過的基因測試
* I consent / do not consent for materials from this sample to be stored / used anonymously for relevant research
* 本人同意 / 不同意從測試中抽取的樣本可被儲存或不具名地用作其他有關的研究

Signed 簽署: _____
Date 日期 (dd/mm/yyyy): / /

** Please cross-out where applicable*
* 請將不適用者刪去

Doctor
醫生

I have explained the purpose of obtaining a blood or tissue sample for genetic testing
本人已解釋收取血液或組織樣本作基因測試的目的

Signed 簽署 _____
Date 日期 (dd/mm/yyyy): / /

This consent form is used with diagnostic testing. Please contact our Professor if you have queries about this consent or counselling issues.
此同意書與診斷測試一起使用。如有任何關於此同意書或診症方面的問題，請聯絡本系的教授。