eurofins | Biomnis

Clinical Information Form
Genetic characterisation of male infertility

INTERNATIONAL DIVISION
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Customer number:

REFERRING PHYSICIAN

First name(s): ..... Last name: .....
Address: .....
Postcode: ⌊_⌊_⌊_⌊_⌊_⌋ City: .....
Country: ..... E-mail: .....
Tel.: ⌊_⌊_⌊_⌊_⌊_⌊_⌋ Fax: ⌊_⌊_⌊_⌊_⌊_⌊_⌋

Physician's stamp

PATIENT (INDEX CASE)

First name(s): ..... Last name: .....
Name at birth: .....
Date of birth: ⌊D_D⌋⌊M_M⌋⌊Y_Y_Y_Y⌋
Address: .....
Postcode: ⌊_⌊_⌊_⌊_⌊_⌋ City: .....
Country: .....

Date of sample collection: ⌊D_D⌋⌊M_M⌋⌊Y_Y_Y_Y⌋

OTHER PHYSICIANS INVOLVED IN THE PATIENT'S TREATMENT (andrologist, endocrinologist, reproductive biologist, gynaecologist)

First name(s): ..... Last name: .....
Address: .....
Postcode: ⌊_⌊_⌊_⌊_⌊_⌋ City: .....
Country: ..... E-mail: .....
Tel.: ⌊_⌊_⌊_⌊_⌊_⌊_⌋ Fax: ⌊_⌊_⌊_⌊_⌊_⌊_⌋

TYPE OF ANOMALY

- ☐ **Obstructive azoospermia (excretory)**
- ☐ **Non-obstructive azoospermia (secretory)**
- ☐ **Severe oligozoospermia**
- ☐ **Cryptozoospermia**
- ☐ **Other** *(contact us)*: .....

FAMILY HISTORY

Infertile blood relatives ☐ YES ☐ NO

If yes, specify relationship (brother/sister, uncle/aunt/ cousin, specify whether paternal or maternal side).

Consanguinity ☐ YES ☐ NO

Geographical origin*: .....

*(*The frequency of genetic variants differs according to the ethnic/geographical origins of the patient)*

Family tree

CONSENT FOR TESTING OF AN INDIVIDUAL'S GENETIC CHARACTERISTICS

(In accordance with Articles R.1131-4 R.1131-5 and the Code of Public Health).

I the undersigned .....
born on ⌊D_D⌋⌊M_M⌋⌊Y_Y_Y_Y⌋

acknowledge that I have been informed by Dr:

.....

on the tests of genetic characteristics that will be performed in order to:

- ☐ *confirm or reject the diagnosis of a genetic disease related to my symptoms;*
- ☐ *confirm or reject the pre-symptom diagnosis of a genetic disease; identify healthy carrier status (screening for heterozygote or chromosomal rearrangement);*
- ☐ *evaluate my genetic susceptibility to a disease or to a drug treatment.*

To this end, I agree:

- ☐ *to a biological sample being obtained from me*
- ☐ *to a biological sample being taken from my child or an adult under my guardianship*
- ☐ *to a sample being taken from my foetus.*

I have been informed the results of the examination of genetic characteristics will be presented to me by the above physician in the context of an individual consultation. If examination reveals results other than those expected, the above-named physician will determine further investigations during an individual consultation.

If part of the sample remains unused after examination,

- ☐ *I agree to its use, if appropriate, for scientific research purposes. In this case, all the medical data about me will be protected by complete anonymisation. As a result of this I am aware that these scientific studies will neither benefit me nor put me at risk.*

Signed in .....
on [date] ⌊D_D⌋⌊M_M⌋⌊Y_Y_Y_Y⌋

Signature of adult patient or legal guardian of the child or legal guardian of an adult under guardianship:

CERTIFICATE OF CONSULTATION

(Decree no. 2008-321 of 4 April 2008 – enacted May 27, 2013).

I the undersigned .....
a physician, in accordance with Articles R.1131-4 and R. 1131-5 of the Code of Public Health, certify that I conducted a consultation with the patient named below on this date to provide him/her with information on investigated disease characteristics, means for detecting such mutations and the options for prevention and treatment.

Signed in .....
on [date] ⌊D_D⌋⌊M_M⌋⌊Y_Y_Y_Y⌋

Signature of the physician:

R51-INTGB - December 2022

SAMPLE REQUIREMENTS

☐ 5 ml of ETDA whole blood at room temperature (refrigerate sample if transport > 48H) and/or ☐ a tube of extracted DNA at room temperature (minimum volume 50µL and minimum quantity 1µg)

CLINICAL AND BIOLOGICAL ASSESSMENT

Clinical details

Age ..... years Weight..... kg
Height ..... cm
Testicular volume: ..... ml
Primary/secondary infertility,
Specify the duration: .....

Bilateral cryptorchidism	☐ YES	☐ NO
Epididymitis *(uni- or bilateral)*	☐ YES	☐ NO
Acute torsion of the testicle	☐ YES	☐ NO
Testicular trauma	☐ YES	☐ NO
Orchitis	☐ YES	☐ NO
Chemoradiotherapy	☐ YES	☐ NO
Exposure to toxic substances	☐ YES	☐ NO
Systemic diseases	☐ YES	☐ NO
Kidney failure	☐ YES	☐ NO
Absence of vas deferens	☐ YES	☐ NO

Please specify: .....

Epididymis abnormality (absence, dilatation)	☐ YES	☐ NO
Delayed onset of puberty, hypogonadism	☐ YES	☐ NO
Scrotal/endorectal ultrasound	☐ YES	☐ NO

if yes, attach report

External genital organ anomalies	☐ YES	☐ NO
Morphological anomalies	☐ YES	☐ NO
Abnormal hair	☐ YES	☐ NO
Gynaecomastia	☐ YES	☐ NO

Biological examination

Semen analysis

Volume ..... pH.....
No. of sperm..... No. of round cells.....

Analysis of hormone levels

FSH: .....
LH: .....
Testosterone: total .....
Inhibin B: .....
Seminal plasma markers: .....
Alpha-glucosidase: .....
L-carnitine: .....
Fructose .....
Citric acid .....
Acid phosphatase .....

GENETIC TESTS ALREADY PERFORMED

Karyotype performed ☐ YES ☐ NO
Abnormal result *(please specify):* ..... *Please enclose the report*

Testing for microdeletions of AZF regions ☐ YES ☐ NO
Abnormal result *(please specify):* ..... *Please enclose the report*

Testing for mutations of the CFTR gene ☐ YES ☐ NO
Abnormal result *(please specify):* ..... *Please enclose the report*

Chromosomal microarray analysis (CMA) / Array CGH ☐ YES ☐ NO
Abnormal result *(please specify):* ..... *Please enclose the report*

List of documents to be included with the request

- ☐ *Consent and signed genetic counselling form*
- ☐ *Semen analysis (preferably two)*
- ☐ *Analysis of hormone levels*
- ☐ *Report of genetic analyses performed*
- ☐ *Copy of the pathological anatomy report, if a testicular/epididymal biopsy was performed*
- ☐ *Surgery report (urologist)*

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