Indication for Trophectoderm Analysis according to the Reproductive Medicine Act (FMedG)

Concerning the couple:

..... and
Last name, first name of the patient (in block letters)

.....
Last name, first name of the patient (in block letters)

The physician hereby confirms that at least one of the following criteria applies to the above-mentioned couple:

☐ Following three or more transfers of viable cells during fertility treatment, pregnancy could not be achieved, and there is reason to believe that this is due to a genetic disposition of the viable cells rather than other causes.

☐ At least three medically documented miscarriages or stillbirths occurred spontaneously and were, with high probability, caused by the genetic disposition of the child.

☐ Due to the known genetic disposition of at least one parent (e.g., karyotype in case of translocation):

.....

there is a serious risk of miscarriage, stillbirth, or hereditary disease in the child.

The patient thus meets the criteria outlined in § 2a (1) of the Amendment to the Reproductive Medicine Act for the performance of preimplantation genetic diagnosis.

A signed declaration of consent from the female patient for the genetic analysis is enclosed.

	Name of the referring institution
	Street and house number
Stamp of the referring institution	**Postal code, city**

PLACE, DATE	**SIGNATURE OF REFERRING PHYSICIAN**