ORDER FORM

Clinic's information

Patient code:.....

Clinic:.....

Physician:.....

Address in short:..... Country:.....

Phone:..... Email:.....

Patient's information

Birth date (dd.mm.yyyy): .....

Have you ever smoked? yes ☐ no ☐

Are you currently a smoker? yes ☐ no ☐

How many cigarettes per day you smoke? :.....

Weight (kg):..... Height (cm):.....

How old were you when your periods started (years)? : .....

How old was your mother when she had her menopause (years)? : ..... Do not know ☐

Not in menopause yet ☐ Please state your mother's current age (years): .....

Do you have any biological children? yes ☐ no ☐

Are you part of a multiple birth? (Do you have twin or triple sisters/brothers?) yes ☐ no ☐

Have you been diagnosed with any of the following conditions (either in association with your infertility complaints or separately): endometriosis, polycystic ovary syndrome, premature ovarian insufficiency, tubal infertility? Fill in which one applies, if any.

.....

Hereby I confirm that I am aware that Tervisetehnoloogiate Arenduskeskus AS is using my data for calculation of my personal risk score and further development of the service. I am aware that DNA extraction can fail and produce no valid results, whereafter I will be receiving a new free test.

Signature of the patient:.....

THIS FORM MUST ACCOMPANY EACH SAMPLE

Tervisetehnoloogiate Arenduskeskus AS
fertify@ccht.ee

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