

PITTSBURGH GENETICS AND GENOMICS CENTER



Preimplantation Genetic Screening (PGS) Requisition form

PATIENT INFORMATION <i>(Please Print):</i>	IVF REFERRING PHYSICIAN <i>(Please Print):</i>
Last Name: _____ First: _____ M.I.: _____	Name: _____
Address: _____ Home Phone #: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Birthdate: _____ SS#: _____	Telephone: _____
Medical Record #: _____ Account#: _____	Fax: _____
Send Bill To: _____ Insurance (please attach insurance info.) _____ Patient _____ Institution(list):	Additional Report To: _____
SPECIMEN INFORMATION:	CYCLE INFORMATION:
Type of Specimen: _____ Trophectoderm (Day 5) Embryo #: _____ _____ Trophectoderm (Day 6) Embryo #: _____ Total number of embryos for study: _____	Stimulation Start Date: _____ Projected Egg Retrieval Date: _____ Date/Time of Collection: _____
INDICATION FOR STUDY: <i>(MUST BE COMPLETED!)</i>	
<input type="checkbox"/> Advanced Maternal Age <input type="checkbox"/> Repeated Pregnancy Losses <input type="checkbox"/> History of Multiple congenital anomalies <input type="checkbox"/> Infertility <input type="checkbox"/> Carrier of Chromosome abnormality (specify) _____ <input type="checkbox"/> Other (list): _____	
Genetic Counseling (Counselor, date) _____ Consent forms (signed date) _____	
TEST(S) REQUESTED: <i>(MUST BE COMPLETED!)</i>	
_____ <i>Aneuploidy Microarray Testing</i>	
Signature of Requesting Physician <i>(REQUIRED!)</i> :	
Lab Accession # _____	Tech.: _____ Date Received: _____