

# Requisition Form Preimplantation Genetic Screening (PGS)



## Clinic Information

Clinic Name \_\_\_\_\_ Referring Physician \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Clinician \_\_\_\_\_ Tel \_\_\_\_\_ Fax \_\_\_\_\_  
Email \_\_\_\_\_ Physician's Signature \_\_\_\_\_

## Patient Information

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  F  M  
Partner Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  F  M  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Tel \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_  
Egg donor used?  No  Yes *If yes, donor age* \_\_\_\_\_ Male factor?  No  Yes *If yes:*  TESE  ICSI  Donor sperm

## Cycle Information

Anticipated Biopsy Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Biopsy Type:  Day 3 – Blastomere  Day 5/6 – Blastocyst

### Cycle Planning

- Results needed for **fresh transfer** (NGS only)
  - Day 3 biopsy for Day 5 transfer
  - Day 5/6 biopsy for Day 6/7 transfer (*local clients only*)
- All embryos will be cryopreserved for **future transfer**

### Cycle Planning (continued)

- Analyze samples received
- All samples provided are to be frozen and banked for future analysis
- Please analyze the included samples along with all frozen banked samples from this patient

## Clinical History & Testing Options

### Reasons for Referral (*select all that apply*)

- Maternal age >35 years
- Multiple failed IVF cycles (*Number of prior cycles:* \_\_\_\_\_)
- Recurrent pregnancy loss (*Number of Miscarriage / IUIDs:* \_\_\_\_\_)
- Reproductive failure (*Parental karyotypes performed?:*  No  Yes, normal)
- Personal / Family Planning: \_\_\_\_\_
- Evaluate for aneuploidy: \_\_\_\_\_
- Other: \_\_\_\_\_

### Preimplantation Genetic Screening (PGS) Option

- CombiPGS by Next Generation Sequencing (NGS)

**PLEASE NOTE:** For cases in which both partners are carriers for the same recessive genetic disorder, cases in which a patient or her partner are affected with a dominant or X-linked genetic disorder and cases in which one or both partners are carriers of a balanced chromosome rearrangement / translocation the couple may wish to consider preimplantation genetic diagnosis (PGD).

## Billing Information

Please bill:  My account  Patient

For patient billing, please direct patient to: [www.combimatrix.com/pgsconsent](http://www.combimatrix.com/pgsconsent) to complete the Patient Consent and Payment Authorization forms. Results will not be released until the full payment amount is received. **NOTE:** CombiMatrix does not accept patient insurance for PGS.

## Special Instructions / Additional Information