PGS Requisition Form

www.PacGenomics.com
818-597-1938

Fax to 818-936-0511 or email to info@PacGenomics.com

REFFERING FACILITY INFORMATION		
Referring Physician:		Referring Physician Signature:
Facility Name:		
Street Address:		
City:	State:	Zip Code:
Fax (to send report):	E-mail (to send report):	
Main phone:	IVF Lab phone:	Emergency phone:
Main contact person:	Role: ☐ Physician ☐ IVF Coordinator ☐ Embryologist ☐ Other	

PATIENT INFORMATION			
Patient Name:	DOB: ___ /___ /_____ *(mm/dd/yyyy)*		
Partner Name:	Partner Age:		
If egg donor, donor Age:			
Phone number:	Email address:		
Mailing address:			
# previous conceptions:	# previous miscarriages:	# previous deliveries:	# previous IVF cycles:

Date of expected egg retrieval: _____

Day of expected biopsy: ☐Day **3** biopsy ☐Day **4** biopsy ☐Day **5** biopsy ☐Day __ biopsy

Cycle details:

- ☐ Per Embryo
- ☐ Batching

Turnaround time:

- ☐ Rush
- ☐ Routine

Reasons for requesting PGS test:

☐ Advanced maternal age ☐ Previous IVF failure (please indicate # of cycles: __) ☐ Previous miscarriages
☐ Translocation ☐ Parental aneuploidy ☐ Family balance and sex selection
☐ Family history (including previous child born with chromosomal and genetic disorder)
☐ Other (please describe:_____)

Please describe outcome of IVF cycles and previous aneuploidy conceptions:

TEST REQUESTED:

- ☐ Microarray-based PGS
- ☐ Next Generation Sequencing-based PGS
- ☐ Translocation Study

Special Request

- ☐ _____