



# PGS Requisition Form

[www.PacGenomics.com](http://www.PacGenomics.com)

818-597-1938



Fax to 818-936-0511 or email to [info@PacGenomics.com](mailto:info@PacGenomics.com)

REFERRING 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: <input type="checkbox"/> Physician <input type="checkbox"/> IVF Coordinator <input type="checkbox"/> Embryologist <input type="checkbox"/> 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: <input type="checkbox"/> Day <u>3</u> biopsy <input type="checkbox"/> Day <u>4</u> biopsy <input type="checkbox"/> Day <u>5</u> biopsy <input type="checkbox"/> Day __ biopsy			
Cycle details:			
<input type="checkbox"/> Per Embryo			
<input type="checkbox"/> Batching			
Turnaround time:			
<input type="checkbox"/> Rush			
<input type="checkbox"/> Routine			
Reasons for requesting PGS test:			
<input type="checkbox"/> Advanced maternal age <input type="checkbox"/> Previous IVF failure (please indicate # of cycles: __) <input type="checkbox"/> Previous miscarriages			
<input type="checkbox"/> Translocation <input type="checkbox"/> Parental aneuploidy <input type="checkbox"/> Family balance and sex selection			
<input type="checkbox"/> Family history (including previous child born with chromosomal and genetic disorder)			
<input type="checkbox"/> 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

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