Sample Cell Collection Form

Preimplantation Genetic Testing

www.PacGenomics.com

818-597-1938

Patient Name: _____

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

REFERRING FACILITY INFORMATION			
Facility Name:	Referring Physician:		
Address:	City:	State:	Zip code:
Fax (to send report):	E-mail (to send report):		

PATIENT INFORMATION	
Patient Name:	DOB: __/__/_____ *(mm/dd/yyyy)*
Partner Name:	Partner Age:
If egg donor, donor Age:	
Patient contact information:	

BIOPSY INFORMATION				
Date of biopsy: Date of re-biopsy (if applicable):				
Day of embryo development when biopsied:	☐Day 3 biopsy	☐Day 4 biopsy	☐Day 5 biopsy	☐Day _ biopsy

Cycle details:

☐ Results needed for fresh embryo transfer

Date and **time** of expected FET: _____

☐ All embryos will be cryopreserved for future transfer

☐ Samples for banking (intended for future batched analysis)

Biopsied by: _____ Biopsied cell loaded into tube by: _____

Urgent contact phone number (cell phone preferred): _____

Negative control tube #: _____ and _____

Sample Cell(s) Record

Tube #	Embryo grading	Number of cells biopsied	Nucleus seen? Y/N	Cell intact? Y/N	Note

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