Requisition Form
Preimplantation Genetic Screening (PGS)

INVITAE | CombiMatrix

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 / IUFDs: _____)*
- ❑ 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** 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

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