PITTSBURGH GENETICS AND GENOMICS CENTER

UPMC
LIFECHANGINGMEDICINE

Preimplantation Genetic Screening (PGS) Requisition form

PATIENT INFORMATION (*Please Print*):	**IVF REFERRING PHYSICIAN (*Please Print*):**
Last Name: First: M.I.:	Name:
Address: Home Phone #:	Address:
City, State, Zip:	City, State, Zip:
Birthdate: SS#:	Telephone:
Medical Record #: Account#:	Fax:
Send Bill To: _____Insurance (please attach insurance info.) ____ Patient _____ Institution(list):	Additional Report To:
SPECIMEN INFORMATION:	**CYCLE INFORMATION:**
Type of Specimen: **_____ Trophectoderm (Day 5) Embryo #:** **_____** **_____ Trophectoderm (Day 6) Embryo #:** **_____** **Total number of embryos for study: _____**	**Stimulation Start Date: _____** **Projected Egg Retrieval Date: _____** **Date/Time of Collection: ___**

INDICATION FOR STUDY: (*MUST BE COMPLETED!*)

____ Advanced Maternal Age
____ History of Multiple congenital anomalies
____ Carrier of Chromosome abnormality (specify)_____
____ Other (list): _____
____ Repeated Pregnancy Losses
____ Infertility

Genetic Counseling (Counselor, date) _____ Consent forms (signed date) _____

TEST(S) REQUESTED: (*MUST BE COMPLETED!*)

____ Aneuploidy *Microarray Testing*

Signature of Requesting Physician (REQUIRED!):

Lab Accession # Tech.: _____ Date Received:

Magee-Womens Hospital of UPMC
300 Halket St.,
Pittsburgh, PA 15213

IVF Center: (412)641-7463 PHONE (412)641-1077 FAX
Genetic Clinic: (412)641-4168 PHONE (412)641-1032 FAX
Genomics Lab: (412)641-2949 PHONE (412)641-2893 FAX
Cytogenetics Lab: (412)641-5558 PHONE (412)641-2255 FAX

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