**BlastoGen**
**Preimplantation Genetic Screening (PGS)**
**24 Chromosome Aneuploidy Screening with aCHG**
**Account Set up Form**

## CLINIC INFORMATION

**Referring Center**:_____

# IVF Cycles/year:_____ # PGS (Aneuploidy):_____ # PGD (Single Gene Disease) _____

**Referring Physician(s)**:

Name _____Last Name _____Tel:_____ e mail _____

Name _____Last Name _____Tel:_____ e mail _____

Name _____Last Name _____Tel:_____ e mail _____

Name _____Last Name _____Tel:_____ e mail _____

Name _____Last Name_____Tel:_____ e mail _____

Street Address: _____

City, State, Zip code: _____

Telephone:_____ Fax:_____

Primary Contact:_____ Office Hours:_____

Emergency Contact information:_____

**Laboratory:**

Street Address (if different than above): _____

City, State, Zip code: _____

Telephone:_____ Fax:_____

Primary Laboratory Contact:_____ Email: _____

Laboratory Office Hours: _____

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## ACCOUNT/BILLING INFORMATION

**Preimplantation Genetic Screening (PGS)**

☐ Patient ☐ Clinic

Complete only if Clinic is to be billed:

Send invoice the attention of:_____

Address (if different from clinic address):_____

Phone:_____ Email:_____

**PGS Result Deliver Counseling Reports Delivery:**

☐ Fax ☐ Email ☐ Both

Fax: _____ Email: _____

**Genetic Counseling Reports Delivery:**

☐ Fax ☐ Email ☐ Both

Fax: _____ Email: _____

The fax number or email account provided should be secure and compliant with HIPAA regulations.

Transfers time (Window) _____am: _____ pm

Test Results received by? _____ Latest time: _____

Contact Person Name and Phone # (weekday) to discuss results _____

Contact Person Name and Phone # (weekend) to discuss results _____

***By accepting reports by facsimile and/or email, you accept full responsibility for compliance of such communications with HIPAA regulations and for the security of the information contained therein.***

**Special Instructions:**

_____

_____

☐ Please check here if you do ***not*** wish to have your clinic name added to our website.