BLASTOGEN

PGS-Requisition Form
(Polar Bodies, Blastomere or Trophectoderm)
24 Chromosome Aneuploidy Screening with aCGH

Patient Information		
Patient Last Name :	First Name:	Birth Date:
Partner Last Name :	First Name :	Birth Date:
Patient Billing Address (required):	Patient Telephone:	Patient Email:

IVF Clinic Information	
Name of IVF Clinic	
Referring Physician	
Street Address	
City, State, Zip code	

AUTHORIZED REFERRING PROVIDER

Name: Signature:

Reason for Referral

☐ Advanced Maternal Age ☐ Male Factor ☐ Translocation ☐ Unexplained Infertility

☐ Sex Selection ☐ Previous IVF Failure ☐ Previous Aneuploidy ☐ Other

☐ Repeat Pregnancy Loss- Please indicate # of losses _____

☐ Previous IVF Failure- Please indicate # of cycles _____

☐ Egg donor (Date of Birth:)

Day of Biopsy	☐ Day 3 ☐ Day 5 ☐ 1st Polar Body ☐ 2nd Polar Body
Planned Embryo Transfer	☐ Next day after biopsy ☐ Embryo Freezing after biopsy
Anticipated Egg Retrieval Date (if known):	

Testing

☐ 24-chromosome aneuploidy screening ONLY

☐ Robertsonian translocation/reciprocal translocation/inversion testing plus 24-chromosome aneuploidy screening (please fax patient karyotype)