UPMC
LIFE CHANGING MEDICINE

UPMC Cytogenetics Laboratory
Preimplantation Genetic Testing 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 #: _____** ☐ **Trophectoderm (Day 7) 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!*)

☐ **PGT-A (aneuploidy)**
☐ **PGT-SR (structural rearrangement)**

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, fax: (412)641-1077
Genetic Clinic: (412)641-4168, fax: (412)641-1032
Genomics Lab: (412)641-2949, fax: (412)641-2893
Cytogenetics Lab: (412)641-5558, fax: (412)641-2255

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