

**UPMC Cytogenetics Laboratory  
Preimplantation Genetic Testing Requisition Form**

<b>PATIENT INFORMATION (Please Print):</b>		<b>IVF REFERRING PHYSICIAN (Please Print):</b>	
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: _____	
<b>SPECIMEN INFORMATION:</b>		<b>CYCLE INFORMATION:</b>	
<b>Type of Specimen:</b> Trophectoderm (Day 5) Embryo #: _____ Trophectoderm (Day 6) Embryo #: _____ Trophectoderm (Day 7) Embryo #: _____ Total number of embryos for study: _____		<b>Stimulation Start Date:</b> _____ <b>Projected Egg Retrieval Date:</b> _____ <b>Date/Time of Collection:</b> _____	
<b>INDICATION FOR STUDY: (MUST BE COMPLETED!)</b>			
<input type="checkbox"/> Advanced Maternal Age <input type="checkbox"/> History of Multiple congenital anomalies <input type="checkbox"/> Carrier of Chromosome abnormality (specify): _____ <input type="checkbox"/> Other (list): _____		<input type="checkbox"/> Repeated Pregnancy Losses <input type="checkbox"/> Infertility	
Genetic Counseling (Counselor, date): _____		Consent forms (signed date): _____	
<b>TEST(S) REQUESTED: (MUST BE COMPLETED!)</b>			
<input type="checkbox"/> PGT-A (aneuploidy) <input type="checkbox"/> PGT-SR (structural rearrangement)			
<b>Signature of Requesting Physician (REQUIRED!):</b>			
_____ _____			
Lab Accession # _____		Tech.: _____ Date Received: _____	