Fairfax Diagnostics ◊ PGT Laboratory Test Request Form (TRF)

3015 Williams Drive ◊ Fairfax, VA 22031

Patient Information

Patient's Name: ______________________________ DOB: ______________
Last First MI (MM/DD/YY)

ID Number/SSN ________________________________

Test(s) Requested

☐ PGT-A (Next Generation Sequencing for Aneuploidy)

☐ PGT-SR (Next Generation Sequencing for Structural Rearrangements)

☐ Pre-cycle workup for PGT-M

☐ PGT-M Monogenic Disease Prevention: (Name): ______________________

Specimen Information

Specimen Type:

☐ Peripheral Blood Specimen: Date of collection: __________Time of collection:________# of tubes:__________

☐ 8 cc Lavender top / EDTA (for PGT-M)

☐ Trophectoderm: Date of biopsy: __________________ (MM/DD/YY)

☐ Other ____________________

Special Considerations: Oocytes were inseminated by intracytoplasmic sperm injection (ICSI) unless otherwise indicated.

☐ Donor oocyte ☐ Donor sperm ☐ Previously cryopreserved oocytes warmed

☐ Oocytes were inseminated by conventional IVF ☐ Previously cryopreserved embryos thawed for biopsy

Clinical Indication for test (check all appropriate):

☐ Advanced Reproductive Age (ARA)

☐ Recurrent Miscarriage

☐ Gender Selection (please specify):

☐ Male

☐ Female

☐ Monogenic Disease Prevention:

(Disease Name): ____________________

☐ Structural chromosome rearrangement:

(Abnormal Karyotype):____________________

☐ Other (please specify): ____________________

Client Information

Complete Facility Name: ______________________ FD Source Code: ______________

Ordering Physician Name: ______________________ Contact Person: ______________

Reporting Phone Number: ______________________ Facility Fax Number:______________

Reporting Address: ____

____

Consent:

☐ This patient received appropriate information about the nature of the testing process and gives informed consent to have testing performed. In addition, the patient also consents to release relevant information on the outcome of her cycle to this laboratory.

Physician Signature: ______________________________

PGT Lab Use Only

Date specimen rec'd: ______________ Time specimen rec'd/tech. initials: ______________

Case #: ____________ Accession Date: ______________ # Embryos Biopsied: ____________

Number of tubes: ____________ Condition: ☐ OK ☐ Other: ______________________