Test Request Form

Patient Information

Patient's Name: _____ DOB: _____

Last First MI (MM/DD/YY)

Clinic ID Number: _____

Test(s) Requested

☐ PGT-A (Next-Generation Sequencing for Aneuploidy)
☐ PGT-SR (Next-Generation Sequencing for Structural Rearrangement)
☐ PGT-M Monogenic Disease Prevention:

(Disease/Gene Name) _____

Specimen Information

Clinical Indication for test (check all appropriate):

☐ Advanced Reproductive Age (ARA)
☐ Recurrent Miscarriage
☐ Gender Selection (please specify):
  ☐ Male
  ☐ Female
☐ Structural chromosome rearrangement:

(Abnormal Karyotype): _____

☐ Genetic Disease Prevention:

(Disease/Gene Name) _____

☐ Other (please specify): _____

PGT-M:

If you selected PGT-M, please email info@fairfaxdiagnostics.com for more information regarding pre-cycle workup.

Fairfax Diagnostics

Client Information

Complete Facility Name: _____

Ordering Physician Name: _____

Reporting Phone Number: _____ Facility Fax Number: _____

Contact Person: _____

Email: _____

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:

_____

To submit this Test Request online, please complete the appropriate fields and attach to the completed Contact Form for submission at:

www.fairfaxdiagnostics.com/contact-us/

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: _____