Fairfax Diagnostics

Test Request Form

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 Rearrangement)
☐ PGT-M Monogenic Disease Prevention: (Name): _____

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:

_____

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Specimen Information

PGT-SR: Clinical Indication for test (check all appropriate):

☐ Advanced Reproductive Age (ARA)
☐ Recurrent Miscarriage
☐ Gender Selection (please specify):
  ☐ Male
  ☐ Female
☐ Genetic Disease Prevention:
  (Disease Name): _____
☐ Structural chromosome rearrangement:
  (Abnormal Karyotype):_____
☐ Other (please specify): _____

PGT-M:

Specimen Type:

☐ Peripheral Blood Specimen:

Collection Date: _____ Collection Time: _____ # of tubes: _____

(MM/DD/YY)

☐ 8 cc Lavender top / EDTA (for Single Gene Disorder)

☐ Trophectoderm: Biopsy Date: _____

(MM/DD/YY)

☐ Other _____

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: _____