TEST REQUISITION FORM FOR PREIMPLANTATION GENETIC TESTING (PGT)

Submit completed form and requested genetic testing results to info@novagenomics.org or fax #: 571-697-1801

Intended Parent 1 Demographics		Intended Parent 2 Demographics or ☐ N/A	
Last Name:		Last Name:	
First Name:		First Name:	
DOB:	Sex:	DOB:	Sex:
Email:	Phone:	Email:	Phone:
Street Address:		Street Address or ☐ Same as IP1's Address:	

Donor Gamete or ☐ N/A

☐ Donor Oocyte | ID Number: _____ Donor DOB: _____ ☐ Donor Sperm | ID Number: _____ Donor DOB: _____

Sample Type

☐ Trophectoderm Biopsy
Processed upon receipt
Estimated Cycle Start Date: ___ / ___ / _____

☐ Repeat Trophectoderm Biopsy
Cycle Date: ___ / ___ / _____
Embryo Number: _____

☐ Other (select one)
Peripheral Blood (4cc EDTA) | Buccal Swab | Saliva
Date of Collection: ___ / ___ / _____
Time of Collection: _____

Test Requested and Indication

☐ **PGT-A**
For aneuploidy screening by NGS

☐ **PGT-SR and PGT-A performed simultaneously**
For structural rearrangement and aneuploidy screening by NGS
Please attach the abnormal chromosome report

A case review is required prior to shipping biopsies.

☐ **PGT-M and PGT-A performed simultaneously**
For disease prevention (requirement: specify gene(s) _____) and aneuploidy screening by NGS
Name/relationship of individuals in the family positive for the disease (requirement: please specify) _____

Please attach prior genetic testing reports and genetic consultations
Appropriate documentation is required for case review. If case is accepted, a customized test must be developed prior to shipping biopsies.

IVF Center Information

Facility Name:	
Street Address:	
City, State, Zip Code:	
Facility Phone:	Facility Fax:
Facility Email:	
Contact Name:	
Contact Phone:	Contact Fax:
Contact Email:	
Preferred Fax Number for Test Reporting (if different than above):	

Statement of Informed Consent

As the ordering Healthcare Provider, I certify that: (1) I have obtained the intended parent(s) verbal and written informed consent to perform this test, which I will maintain on file and make available to NOVA Genomics upon request; (2) The intended parent(s) has/have been appropriately counseled and understand the risks, benefits, limitations, and alternatives of this genetic testing and the implications of the results; (3) The intended parent(s) is/are aware of the availability of genetic consultation with a Certified Genetic Counselor regarding this test; (4) I have received the intended parent(s) consent for NOVA Genomics to use and disclose information, test results, and sample as described in the NOVA Genomics Informed Consent Form; (5) I have obtained consent from the intended parent(s) to be contacted by NOVA Genomics via email, phone or text message; and (6) I agree to release relevant information on the outcome of the IVF/FET cycle to this laboratory.

Ordering Physician Name:	
NPI:	
Ordering Physician Signature:	Date:

