RGI REPRODUCTIVE GENETIC INNOVATIONS LLC
2910 MacArthur Boulevard, Northbrook, IL 60062
Phone: 847-400-1515 **Fax:** 847-400-1516
E-mail: info@rgiscience.com **Website:** www.rgiscience.com

PREIMPLANTATION GENETIC TESTING (PGT) REQUISITION FORM

1. Patient information

Patient (Last Name, First Name): DOB: SSN (last 4 digits):

Partner (Last Name, First Name) DOB: SSN (last 4 digits):

Address:

City: State: Zip: Country:

Patient Phone #: PT e-mail:

Partner Phone #: PRT e-mail:

☐ Egg Donor (DOB + ID): ☐ Sperm Donor (DOB + ID):

2. Biopsy/Transfer/Batching Details

Biopsy: ☐ Blastocyst/TE (Day 5/6) ☐ Day 4 (requires RGI embryologist) ☐ Blastomere (Day 3) ☐ Re-biopsy Cycle: embryo #

Transfer: ☐ Frozen Embryo Transfer (FET) ☐ Fresh Day 5 (For day 0/1/3 biopsies only)

Batching: *(we will test unless otherwise specified)* ☐ Batch & Hold (do not test)

3. Setup/Test Request(s) *(Select **all** that apply & include appropriate reports)*

☐ Aneuploidy (PGT-A) by Next-Generation Sequencing 24-Chromosomes(NGS; recommended for TE samples only)
- ☐ Do not disclose sex
- ☐ Do not report mosaicism

☐ Single gene disorder (PGT-M):

☐ HLA matching (PGT-HLA) :

☐ Chromosomal rearrangement (PGT-SR) by NGS (Includes 24-chromosome PGT-A; recommended for TE samples only)

Additional details regarding testing strategy:_____

4. Cycle information – *please confirm at time of hCG*

	Tentative Dates (MM-DD-YY)	Confirmed Dates (MM-DD-YY)
Stimulation start:		
hCG:		
Retrieval:		
Biopsy:		
Transfer/Freeze:		

Date of update: _____ Date of update: _____

5. ICD-10 Format Diagnosis/Symptoms:

(Also include relevant reports)

_____

_____

_____

6. IVF Center Information *Please specify if address for buffer is different.*

Name of IVF Center _____ Phone # _____

Full Address _____

Referring Physician _____ NPI # _____

Nurse/Coordinator & Email _____

☐ Select this box if you require an RGI Embryologist

7. Reporting Preferences

☐ To patient ☐ Email(s): _____

☐ Fax(es): _____

RGI will provide patients access to results upon patient request

Physician signature _____