RGI REPRODUCTIVE GENETIC INNOVATIONS LLC
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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) ☐ Re-biopsy Cycle: embryo #:

Transfer: ☐ Frozen Embryo Transfer (FET)

Batching: *(will test up receipt 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)
☐ Do not disclose sex

☐ Single gene disorder (PGT-M):

☐ HLA matching (PGT-HLA) :

☐ Chromosomal rearrangement (PGT-SR) by NGS (Includes 24-chromosome PGT-A)

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)

_____

_____

_____

☐ Select this box if the above request or cycle has been cancelled.

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. Billing Preferences

To Patient: ☐ Direct ☐ Aetna or Progyny -or- ☐ To Center
☐ Other_____

8. Reporting Preferences

☐ To Patient ☐ Physician Portal ☐ E-Mail(s) / Fax(es): _____

RGI will provide patients access to results upon patient request

Physician signature _____