ACCESS GENOMICS

**REQUISITION FORM**
Preimplantation Genetic Testing for Aneuploidy (PGT-A)

*Please print legibly*

| **REFFERING FACILITY INFORMATION** | | |
|---|---|---|
| Referring physician: | | Referring physician signature: |
| Facility name: | | |
| Street address: | | |
| City: | Province: | Postal Code: |
| Fax (to send report): | E-mail (to send report): | |
| Main phone: | IVF Lab phone: | Emergency phone: |
| Main contact person: | Role: ☐ Physician ☐ IVF Coordinator ☐ Embryologist ☐ Other | |

| **PATIENT INFORMATION** | | | |
|---|---|---|---|
| Patient name: | DOB: _____ /_____ /_____ *(dd/mm/yyyy)* | | |
| Partner name: | Partner age: | | |
| Egg donor age at retrieval (if applicable): | | | |
| Phone number: | Email address: | | |
| Mailing address: | | | |
| # previous conceptions: | # previous miscarriages: | # previous deliveries: | # previous IVF cycles: |

Reasons for requesting PGT-A test:

☐ Advanced maternal age ☐ Previous IVF failure (please indicate # of cycles: ____) ☐ Previous miscarriages

☐ Patient request ☐ Translocation ☐ Parental aneuploidy

☐ Family history (including previous child born with chromosomal and genetic disorder)

☐ Other (please describe:
_____)

☐ Special instructions_____

## REPORTING OF MOSAIC EMBRYOS

NGS-based PGT-A is able to detect embryo mosaicism. Access Genomics reports an embryo as Mosaic when 30-70% of the cells assayed are aneuploid. We provide an estimation of mosaicism for each sample.

We recommend that all patients with mosaic embryos seek genetic counseling prior to considering transfer. Please indicate your preference regarding the reporting of mosaic embryos:

☐ **Yes** - indicate embryo mosaicism on PGT-A report ☐ **No** - designate mosaic embryos as aneuploid

## PGT-A Package Selection

Please indicate the PGT-A Package you are selecting:

☐ Up to 5 embryos in a single submission (from one IVF cycle)

☐ Up to 8 embryos within 12 months (from multiple IVF cycles). Timeline starts on the date of first sample receipt at Access Genomics.

☐ 1 embryo in a single submission

You may submit additional embryo samples within any package. These will be billed using "Additional Embryo" pricing.
You may change testing programs before the samples are received by Access Genomics.

☐ Additional Embryo(s) _____

## PGT-A Payment Options

Please indicate your preferred method of payment:

☐ Invoice IVF clinic directly

☐ Patient Pay (*please legibly complete the following section*)

Credit Card Type (check one): ☐ MasterCard ☐ VISA

Name as it appears on credit card: _____

Credit card #: _____

Exp date (*mm/yyyy*): _____/_____ CVC code: _____

Amount to be charged: (CAD) $ _____ (refer to Patient Pricing)

*I certify that I am the authorized holder and signer of the credit card referenced above and that all information is complete and accurate. Pursuant to the credit card agreement, I hereby authorize collection of payment by Access Genomics for amount indicated above.*

Signature: _____ Date: _____