PsiGenex™

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www.psigenex.com

Include these items

Completed Requisition → Payment Information → Medical Records → Informed Consent

PGT-A Test Requisition

Patient Information (Fill or attach EMR records)

First Name_____ Last Name_____

Biological Sex ☐ Male ☐ Female DOB____/____/____

Medical Record Number_____

Street Address_____

City_____ State and Zip code_____

Email Address_____

Phone Number_____

Partner Name_____

DOB____/____/____ Biological Sex_____

Ordering Provider

Full Name_____

Phone_____ Fax_____

IVF Lab Contact Information

Lab Contact Name_____

Phone Number_____

Email Address_____

Clinical Indications

- ☐ Advanced maternal age
- ☐ Multiple failed IVF cycles. Number of prior cycles_____
- ☐ Recurrent pregnancy loss. Number of Miscarriage/IUFDs_____
- ☐ Male Infertility
- ☐ Routine Aneuploidy screening
- ☐ Personal/ Family planning
- ☐ Other_____

Testing Options

☐ **PGT for Aneuploidy (PGT-A)** ☐ Do not report mosaicism

Specimen Information

Specimen Type

Trophectoderm (blastocyst) biopsy. Embryos must be frozen after biopsy, PsiGenex cannot accommodate fresh transfers.

Number of embryo biopsies_____

Biopsy Date____/____/____ Send Date____/____/____

Egg Donor?	Sperm Donor?	ICSI ?
☐ No	☐ No	☐ No
☐ Yes, donor's age_____	☐ Yes, donor's age_____	☐ Yes

Re-biopsied embryo included ?

☐ No

☐ Yes, original order ID#_____

Physician Acknowledgment

Confirmation of Informed Consent & Statement of Medical Necessity

I affirm each of the following: I have provided genetic testing information to the patient and the patient has consented to genetic testing. This test is medically necessary, and the results will be used in the patient's medical management and treatment decisions. The person listed as the Ordering Provider is authorized by law to order the test(s) requested herein.

Provider's Signature _____ Date____/____/____

Patient Acknowledgment

I have read the attached Informed Consent document. I give permission to PsiGenex to perform genetic testing as described. I also give PsiGenex permission to share any relevant personal information with my insurance company for billing purposes. I authorize PsiGenex to bill my insurance company for testing. I understand the benefits and limitations of PGT-A.

Patient's Signature _____ Date____/____/____

Billing Information

☐ Institutional Billing (Send invoice to facility above)

☐ Patient Billing Credit Card #_____ Expiration____/____

☐ Loan Provider Company Name_____

Address_____ Policy Number_____

Prior Auth #_____

☐ Insurance Billing (PGT-A insurance coverage is limited to specific plans)

Insurance Company Name_____

Address_____

Policy Holder Name_____

Policy Holder Relationship to Patient_____

Policy Number_____

Prior Auth #_____

ICD-10 Code(s)_____

COLLEGE of AMERICAN PATHOLOGISTS

Clinical Laboratory Improvements Amendments