PGS/PGD REQUEST FORM

GeneLabs X (Pvt) LTD.
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GeneLabs X

Genelabs ID: _____ Contact No/ email ID: _____

Date: _____

1. PATIENT INFORMATION

Patient Name: _____ Patient DOB: _____

Address: _____ Patient ID: _____

Karyotype (if performed) _____

Partner Name: _____ Partner DOB: _____

Karyotype (if performed) _____

2. FERTILITY CLINIC INFORMATION

FERTILITY CLINIC NAME: _____

REFERRING DOCTOR: _____

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3. INDICATION

☐ Age

☐ Recurrent miscarriage

☐ Recurrent IVF failure

☐ Other _____

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4. GENETIC TESTING

☐ PGS for chromosome aneuploidy (All 24 chromosomes)

☐ PGD for monogenic disorders

Specific disease & History _____

Embryo Biopsy Worksheet

Patient Name: _____

Biopsy performed by: _____

Date: _____

	Tube/Embryo no.	Number of cells	Comments
A			
B			
C			
D			
E			
F			
G			
H			
I			
J			
K			
L			

It is the requesting clinic's responsibility to ensure that the patient knows the purpose of the test and that the sample(s) may be stored for future testing related to specific diagnosis for the patient. In submitting this form, the fertility clinic confirms that they have obtained consent for testing and storage.

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Embryologist

For use of GeneLabs X (Pvt) Ltd only

Accession

Date Received: ___ / ___ / _____ Time Received: ___ : ___ Signature:

Lab

Date Received: ___ / ___ / _____ Time Received: ___ : ___ Signature: