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

PREIMPLANTATION GENETIC DIAGNOSIS (PGD & PGS) TEST REQUISITION FORM

1. Patient information

Patient (Last Name, First Name) _____ DOB _____

Partner (Last Name, First Name) _____ DOB _____

Address _____

City _____ State _____ Zip _____ Country _____

Phone # _____ Email Address _____

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

2. Biopsy/Transfer/Batching Details

Biopsy: ☐ Blastocyst/Trophectoderm (Day 5/6) ☐ Day 4 (requires RGI embryologist) ☐ Blastomere (Day 3) ☐ Polar Body (Day 0/1)

Transfer: ☐ Frozen Embryo Transfer (FET) ☐ Fresh Day 5 For day 0/1/3 biopsies only ☐ Fresh Day 6 *Samples must be received by 11 am CST on D5*

Batching: *(we will test unless otherwise specified)* ☐ Batch & Hold ☐ Batch with Rapid Results *(aCGH only)*

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

PGS/Aneuploidy *(Select **one** option below)*: ☐ **Do not disclose sex**

☐ Next-Generation Sequencing 24-Chromosomes (NGS; Recommended for Day 5/6 samples only)

☐ Microarray 24-Chromosomes (aCGH; *RGI-Complete*™; Recommended for Day 5/6 samples only)

☐ Single gene disorder: _____

☐ HLA matching

Translocation Testing *(Select **one** option below)*:

☐ Translocation by NGS (Includes 24-chromosome PGS; Recommended for Day 5/6 samples only)

☐ Translocation by aCGH (Includes 24-chromosome PGS; Recommended for Day 5/6 samples only)

☐ Translocation by FISH (**CALL RGI TO REVIEW PRIOR TO STIM START + requires RGI embryologist + FET**)

+ ☐ 24-chromosome PGS on Trophectoderm biopsy (select aCGH or NGS option in PGS section)
+ ☐ Conversion (requires RGI embryologist)

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 _____

7. Send results to

☐ Email(s) *preferred*: _____

☐ To patient ☐ Fax(es) _____

Additional instructions (RGI's embryologist, etc.): _____

Physician signature _____

Email this form to info@rgipgd.com or fax to 847-400-1516 **prior to stimulation start date**, and **update at the time of hCG**.
If you have any questions, please contact a genetic counselor at 847-400-1515, or Evening/Weekend Phone: 773-851-5774.