Dipartimento Materno Infantile	Genetic testing Requisition Form MO.95.OCT.DMI. FIR	Rev. 00 del 29/08/2012 pag 1 di 1
ient and IVF Clinic Information:		
Patient name/number:	/ Patient	DOB:
Partner name/number:	/ Spouse	
Requesting doctor:	Signa	ture:
Anticipated date of oocyte	Donol	age:
retrieval:		CONSENT FORMS SIGNE
Referring center:	Pł	ione:
Street address:		Fax:
City, Postcode:	E	mail:
Contact in IVF lab:	Me	obile:
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□ Other (please specify) _________ Note: For PGD of single gene disorders extensive test preparation is required – a process requiring 8 weeks or longer. Ovarian stimulation should not begin until confirmation has been received that this process is complete. All patients undergoing oocyte or embryo testing should have access to genetic counseling.