Patient and IVF Clinic Information:

Patient name/number:	/	Patient DOB:	
Partner name/number:	/	Spouse DOB:	
Requesting doctor:		Signature:	
Donor used:		Donor age:	
Anticipated date of oocyte retrieval:		☐ CONSENT FORMS SIGNED	
Referring center:		Phone:	
Street address:		Fax:	
City, Postcode:		Email:	
Contact in IVF lab:		Mobile:	

Test Requested:

Chromosome screening for IVF patients:

☐ Microarray comparative genomic hybridisation (arrayCGH)

PGD for chromosome rearrangements (translocations, inversions, etc):

☐ Robertsonian translocation, reciprocal translocation, inversion ☐ Other structural chromosome abnormalities

PLEASE PROVIDE A COPY OF THE GENETIC REPORT (KARYOTYPE) DESCRIBING THE CHROMOSOME REARRANGEMENT

PGD for single gene disorders:

☐ Single gene disorder (specify) _____ ☐ HLA matching

PLEASE PROVIDE A COPY OF THE GENETIC REPORT DESCRIBING THE DISEASE CAUSING MUTATION

Male factor and sperm analysis

☐ Sperm chromosome analysis ☐ Y-chromosome microdeletion screening

☐ Sperm DNA fragmentation analysis Please provide sperm concentration if known _____

Reason for the chromosome screening (if applicable)

☐ Repetitive miscarriage (≥3 miscarriages) ☐ Advanced maternal age

☐ Previous miscarriage (1 or 2 miscarriages) ☐ Previous aneuploid conceptions

☐ Repetitive IVF failure (≥3 IVF attempts) ☐ X-linked disorder

☐ Previous IVF failure (1 or 2 IVF attempts) ☐ Severe male factor

☐ 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.