AdvaGenix
Advanced Genetic Sciences

p: 301-358-3564 | f: 301-560-5604 | www.advagenix.com
9430 Key West Avenue, Suite 130, Rockville, MD 20850

Reproductive Health Test Requisition

patient information

Last Name | First Name | MI | Date of Birth (mm/dd/yyyy)

Biological Gender
☐ Male ☐ Female

Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ French Canadian ☐ Hispanic ☐ Jewish (Ashkenazi)
☐ Jewish (Sephardic) ☐ Mediterranean ☐ Native American ☐ Pacific Islander ☐ Other _____

Email Address | Mobile Phone

Street Address

City | State | Zip Code | Country

partner and donor information

Last Name - Partner | First Name - Partner | MI | Partner DOB (mm/dd/yyyy)

Partner's Gender
☐ Male ☐ Female

Donor Egg? ☐ Yes ☐ No
Age of Egg Donor _____

Donor Sperm? ☐ Yes ☐ No
Age of Sperm Donor _____

clinic information

Clinic Name		Phone Number	Fax Number	
Address	City	State	Zip Code	Country

Ordering Physician	NPI	Email Address (for report access)

additional clinical or laboratory contacts

Name	Email Address	Name	Email Address
Name	Email Address	Name	Email Address

specimen information

Sample Type:
☐ Embryo cells

Retrieval Date | Biopsy Date | Number of Embryos Biopsied

☐ Trophectoderm Freeze After Biopsy
Was ICSI Performed? ☐ Yes ☐ No

☐ Trophectoderm Next Day Transfer (Advance Notice Required)
Rebiopsy of previously tested embryo(s)? ☐ Yes ☐ No

☐ Blood
Date Blood Sample Collected

☐ Other Tissue Type
Specify _____

testing requested

Please select all that apply:

☐ PGT-A: Aneuploidy

☐ PGT-SR: Structural Rearrangements
Tests embryos for unbalanced chromosome rearrangements from a known translocation or inversion carrier. Aneuploidy testing is included. Karyotype required - Please call for consultation.

☐ PGT-M: Single Gene
Requires mutation reports, and blood for test set-up. Aneuploidy testing is included. Please call for consultation.
Specify Disease to be Tested For:
_____

☐ Preconception Carrier Screening
- ☐ 200 Gene Pan-Ethnic Panel
- ☐ 420 Gene Pan-Ethnic Plus Panel
- ☐ 1523 Exome Panel

☐ Clinical Exome

☐ Whole Genome

☐ Sperm Chromosome

☐ Products of Conception

reason for testing

Please select all that apply:

- ☐ Advanced Maternal Age
- ☐ Routine Screening
- ☐ Family Balancing
- ☐ Other: Please Describe
- ☐ Repeat failed implantation / failed IVF cycles # of failed cycles _____
- ☐ Recurrent pregnancy loss # of miscarriages _____
- ☐ Male factor infertility
- ☐ Known structural chromosomal rearrangement (Karyotype Required)

ICD-10 CODE REQUIRED: Please enter Diagnosis Code below

billing information

☐ **Patient Pay Billing**

AdvaGenix will send an electronic invoice to the patient email listed above.The patient will be responsible for all charges related to this Test Requisition; Insurance will not be billed.

☐ **Clinic Billing**

AdvaGenix will send an invoice to the Clinic listed above. By selecting this option, the Clinic hereby accepts payment responsibility for all charges related to this Test Requisition.

☐ **Insurance Billing: Please contact Patient Care for Eligibility**

Attach front and back of insurance card, clinical notes, medical records, and/or letter of medical necessity (LMN) to prevent delays.

Policyholder Name	Patient Relationship to Policyholder ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Company Name	Insurance Plan ID / Policy Number	Group Number	Plan Type

authorization

By signing this form, the medical professional acknowledges that the patient has been supplied information relating to, and has consented to undergo, genetic testing, substantially as set forth in AdvaGenix's Informed Consent for Genetic Testing. I attest that I am the Ordering Physician, or that I am authorized by the Ordering Physician to order this test, or I am authorized under applicable law to order this test.

Medical Professional Signature	Date

shipping instructions

Sample Type	Container	Comments	Shipping Method
Embryos: Frozen	PGT Insulated Shipping Kit		Fedex Next Day
Embryos: Fresh	PGT Insulated Shipping Kit	Monday - Thursday Only	Same Day Courier Service
Blood	Styrofoam Kit	2 EDTA tubes from each person	Fedex Next Day
Sperm	50 ml conical tube		Fedex Next Day
POC	Sterile collection container		Fedex Next Day

Please visit www.advagenix.com to request specimen collection kits & shipping labels

Please Fax Completed Test Requisition Form to: (301) 560-5604

Include a Copy of Requisition with the Specimen