



Physician Test Order

Patient Enrollment Information

for Preimplantation Genetic Diagnosis – Single Gene (PGD) and/or
“Genesis-24” Preimplantation Genetic Screening (PGS) of Chromosomes/Sexing

Test(s) Being Ordered by Physician (Check any/all boxes)

- PGD (Preimplantation Genetic Diagnosis) for an inherited genetic disorder(s)
 - Including HLA for stem cell transplantation matching to sibling
- PGS (Preimplantation Genetic Screening) with microarray CGH for chromosome aneuploidy
- PGS for chromosome translocation risk using microarray CGH ± molecular markers
- Molecular testing for Gender-X/Y (only)

Reason for Testing: _____
e.g. Cystic Fibrosis; Fragile X; Chromosome Translocation; AMA; Recurrent Pregnancy Loss; IVF Failure; Patient Concern...

Physician Name: _____ Signature: _____ M.D.

Clinical Center Information

Center/Clinic Name: _____ Today's Date: _____

City: _____

IVF Coordinator or Embryologist: _____ Phone: _____ - _____ - _____

Patient/Family Genetic Information

Patient: Last: _____ First: _____
by convention, the woman
Date of Birth 19____ year ____ month ____ day Genetically Affected; a “Carrier”; a “Noncarrier”
(has gene mutation) (Heterozygote) (no inherited disease)

Partner: Last: _____ First: _____
the male partner
Date of Birth 19____ year ____ month ____ day Genetically Affected; a “Carrier”; a “Noncarrier”
(has gene mutation) (Heterozygote) (no inherited disease)

Affected Relative: Last: _____ First: _____
if any; PGD Gene Testing only
Date of Birth 19____ year ____ month ____ day Relationship to Patient _____
(Son, Sister, Mother, Aunt, Nephew ... with this Genetic Disorder)

Patient/Family Contact Information

Patient Address: _____
Home Street Address

City _____ State/Province _____ Country _____ Postcode _____

Phone: _____
Patient Home Patient Work Patient Cell (for urgent contact)

Best Email: _____
Very important for us to interact with you and coordinate your care with the IVF Center

email to: Enroll@GenesisGenetics.org or FAX to: 313-544-4006

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