CooperSurgical®

Preimplantation Genetic Testing Test Requisition Form

EMAIL COMPLETED FORM PRIOR TO SENDING SAMPLES. LEAVING ANY SECTION BLANK OR INCOMPLETE MAY RESULT IN A DELAY TO TESTING.
FOR THE US LAB: EMAIL COMPLETED FORM TO SUPPORT@COOPERGENOMICS.COM I **FOR THE UK LAB:** EMAIL COMPLETED FORM TO GENOMICSSUPPORT@COOPERSURGICAL.COM
ALL FIELDS IN BOLD MUST BE COMPLETED FOR CASE ACCEPTANCE.

PATIENT INFORMATION

Patient 1 First Name _____ **Last Name** _____

DOB ___ (Month) / ___ (Day) / _____ (Year) **Sex:** ◯ Female ◯ Male ◯ Other Patient 1 Clinic ID _____

Patient 2 (Partner) First Name _____ Last Name _____

DOB ___ (Month) / ___ (Day) / _____ (Year) Sex: ◯ Female ◯ Male ◯ Other Patient 2 Clinic ID _____

Phone _____ Address _____ City _____

Email _____ State/Prov. _____ Zip Code _____ Country _____

Gamete Donor Used?:

◯ Egg Donor (Age _____)

◯ Sperm Donor

Donor ID _____ (Egg), _____ (Sperm)

Billing Information | For US and Canada patients only. Please provide a copy of the patient's insurance card (front and back) before testing.

◯ **Bill to Patient**
Patient email & phone number must be provided.

◯ **Bill to Clinic**

Insurance/Fertility Benefit Provider: _____

Member ID: _____ ICD-10 Code: _____

Billing Package Options: ◯ **Single Cycle** ◯ **Multiple Cycles**

MEDICAL HISTORY

Previous Conceptions _____ # Previous Miscarriages _____ # Previous Deliveries _____ # Previous IVF Cycles _____

Primary Diagnosis _____ Male Factor Infertility?: ◯ Yes ◯ No

SPECIMEN INFORMATION

Estimated Egg Retrieval Date ___ (Month) / ___ (Day) / _____ (Year) ◯ Rebiopsy From Report Date ___ (Month) / ___ (Day) / _____ (Year) Rebiopsy Sample ID(s) _____

TEST INFORMATION

Select Test(s)

◯ **PGT-A (Including Genetic PN Check)**
(Preimplantation Genetic Testing for Aneuploidies)

◯ **PGT-SR** (Preimplantation Genetic Testing for Chromosomal Structural Rearrangements) - Karyotype Required
Case review and approval are required prior to biopsy submission.
PGT-A (Including Genetic PN Check) is included with PGT-SR.

◯ **PGT-M** (Preimplantation Genetic Testing for Monogenic/Single-Gene Defects)
Case review and approval are required prior to biopsy submission.
Specify Gene(s): _____ OMIM #: _____
◯ HLA Matching
PGT-A (Including Genetic PN Check) is included for all PGT-M samples.

◯ Report PGT-A on all *(default)*
◯ Report PGT-A on unaffected/ carrier embryos only
◯ Do not report PGT-A

◯ Report PGT-SR on all *(default)*
◯ Report PGT-SR on unaffected/ carrier embryos only

Test Preferences

◯ Report with mosaicism *(default)*
◯ Report without mosaicism
◯ Do not report sex[5]

Select Test Upgrade(s)

Selected upgrade(s) will be added to PGT-A unless another test is selected.

◯ **Select Syndrome Screen℠**
Can be added to PGT-A, PGT-SR, or PGT-M. Includes our select microdeletion and microduplication panel.[1]

◯ **PGT-Complete℠ (parentage testing)**
Can be added to PGT-A, PGT-SR, or PGT-M. Includes parentage confirmation[2] and parental origin of aneuploidy. Requires collection of parental samples. Mosaic reporting required.
◯ Send parental kits to clinic
◯ Send parental kits to patient/partner
◯ Do not send kits *(Kits in-house)*

Retrospective Options

◯ Report PGT-Complete (parentage testing) from previous cycle[3] *Report date:* _____

◯ Unmask mosaicism from previous report[4] *Report date:* _____

◯ Report sex from previous report *Report date:* _____
Specify sample ID(s) in Notes

Notes: _____

IVF CLINIC INFORMATION

IVF Clinic Name _____ **Clinic Code** _____ Address _____

City _____ State/Prov. _____ Zip Code _____

Form Completed By *(Print name)* _____ **Contact Info (Phone/email)** _____ **Date** ___ (Month) / ___ (Day) / _____ (Year)

Ordering Physician's Medical Professional Consent: My signature constitutes a Certification of Medical Necessity. I attest that I have informed the patient about the Preimplantation Genetic Test, as may be required by applicable laws and regulations, and that the patient has provided consent for the test ordered. I understand that the ordered test is intended solely as a screening tool, not a definitive diagnostic procedure, and should not replace any clinical guidelines for embryo selection or recommended prenatal diagnostic tests. I further certify that a request for reporting sex of an embryo prospectively or retrospectively complies with the laws of the country that both the clinic and I operate in.

Ordering Physician _____ (First Name) _____ (Last Name) **Physician Signature** _____

TESTING CAN ONLY BEGIN UPON RECEIPT OF A COMPLETED TRF. PATIENT REPORT WILL NOT BE ISSUED WITHOUT SIGNED PATIENT CONSENT.[6]

Note: Testing is performed by CooperGenomics. 1. Visit www.coopersurgical.com/product/select-syndrome-screen-test/ for more information on the syndromes included in our Select Syndrome Screen test. 2. In countries where confirmation of embryo parentage is not permitted, only origin of aneuploidy is reported. 3. Check with us prior to ordering that samples are eligible for retrospective PGT-Complete (parentage testing). If mosaic reporting was masked on initial testing, PGT-Complete (parentage testing) will unmask mosaics. 4. Check with us prior to ordering that samples are eligible for retrospective mosaic reporting. 5. Sex will not be reported in countries where it is not permitted (e.g. UK, Canada, Australia) unless medically indicated. 6. For the UK laboratory, patient consent is only required for PGT-SR and PGT-M testing.