Department of Obstetrics and Gynaecology

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REQUEST FORM FOR PGD/ PGS

Please stick Female Patient's Label here
(include Name and ID No.)

Name: _____ *Sample collection date:* ___/___/___ *(d/m/y)*

Chinese Name: _____ *Sample collection time:* ___:___ *(h:m)*

HK ID No.: _____ ( ) *Hosp/Clinic No.:* _____ *Referring Clinic:* _____

DOB: ___/___/___ *(d/m/y)* *Sex:* Female *Referring Hospital:* _____

Address: _____ *Telephone No.:* _____ *Fax No.:* _____

Telephone No.: _____ *Referring Doctor:* Dr. _____

Fees to be paid by: ☐ *Patient* ☐ *Referring Doctor* ☐ *Others*

(Name / Address: _____ ***Signature:*** _____

_____ *)* *Remarks*: _____

Clinical history: ☐ Advanced age (≥38) ☐ Translocation carrier: _____

☐ Recurrent abortion: _____ times ☐ Miscarriage ☐ Familial Chr. defect: _____

☐ Others: _____

Fertilization: ☐ IVF ☐ IVF+ICSI

Sample: ☐ Blastomere: _____ Blastocyst: _____ (please indicate the number of embryo biopsied)

☐ Amplified DNA: _____ (please indicate the amplification method used)

Test requested: ☐ aCGH ☐ KaryoLite™ BoBs ☐ PGD *for:* _____

☐ Others: _____

This part for laboratory use only

Genetic work-up for PGD start on: ___/___/___ *(d/m/y)* *Signature:* _____

Genetic work-up for PGD complete on: ___/___/___ *(d/m/y)* *Signature:* _____

PGD/ PGS request (2 days in advance of embryo biopsy)

Request received on: ___/___/___ *(d/m/y)* *Time:* ___:___ *(h/m)*

Lab replied on: ___/___/___ *(d/m/y)* *Time:* ___:___ *(h/m)* *Signature:* _____ *Case code.:* _____

Samples received on: ___/___/___ *(d/m/y)* *Time:* ___:___ *(h/m)* *No. of tubes received:* _____ *Signature:* _____

Check by: _____