Cytogenomix®
Affordable Genomics For All

IAS UQAS
ISO 15189 CERTIFIED

CYTOGENOMIX Sdn Bhd
(202101042245/1442545-M)
1-STOP CENTRE MIDLANDS PARK 3RD FLOOR
488D-3-15, JALAN BURMA, 10350 PENANG, MALAYSIA

Preimplantation Genetic Test Requisition Form

CGx #	

Patient/Intended Mother's Information *(or affix label here)*

Name		Medical Record #	
NIC/ Passport #		Date of Birth	
Address			
Intended Parent #2 Information *(Optional)*			
Name			
NIC/ Passport #		Date of Birth	

Indications for Testing *(select all that apply)*

- ☐ Routine aneuploidy screening
- ☐ Advanced maternal age
- ☐ Recurrent Miscarriages: # of losses:________
- ☐ Male infertility
- ☐ Recurrent IVF Failure; # of failed cycles:________
- ☐ Known structural chromosomal rearrangement ________

	PGT Requested	Additional Information Required
☐	PGT-A – Aneuploidy Screening	
☐	PGT-A PLUS	Heteroploidy testing (including triploidy, parental contamination detection and uniparental disomy-UPD)
☐	PGT-M / PGT-SR Pre-Clinical Workup	Paternal Mutation: ________ Maternal Mutation: ________
☐	PGT-M – Monogenic Disorders	Mutation Inherited: ________
☐	PGT-SR – Structural Rearrangement	Karyotype of the balance translocation carrier:________
☐	PGT-HLA (High Resolution)	Share the HLA report (if available) of the index case
☐	Parental Check	Parental blood (EDTA) required________
☐	Molecular PN Check	________PN (parental blood (EDTA) required)

Requesting Physician

By signing this form, I acknowledge that the patient has been counselled about the purpose, scope and limitations of the PGT-A, PGT-M, PGT-SR, PGT-HLA, PGT clinical set-up and has given consent for genetic testing to be performed. I have supplied information to the patient regarding genetic testing and the patient has given consent for genetic testing to be performed. I further confirm that this test is medically necessary based on my professional judgement for the risk evaluation or will provide information regarding patient's ongoing treatment plan, and the results will be used in the medical management and treatment decisions for the patient requested herein.

Doctor's Name ________________ Hospital/Clinic Name ________________

Embryo Biopsy Information

Biopsies Performed By		# of Biopsied Embryos		Date of Biopsy	

Embryo ID	**Number of cells**	**Embryo Stage**	**Notes**

LB/045/23_V3

CYTOGENOMIX Sdn Bhd
(202101042245/1442545-M)
1-STOP CENTRE MIDLANDS PARK 3RD FLOOR
488D-3-15, JALAN BURMA, 10350 PENANG, MALAYSIA

Embryo ID	Number of cells	Embryo Stage	Notes

LB/045/23_V3