



Patient Intake Information for Preimplantation Genetic Diagnosis

Patient :

By Convention, the Woman

Last _____ First _____

Date of Birth 19__ __ __ Genetically Affected; a "Carrier"; a "Noncarrier"
Year Month Day (Has Gene Mutation) (Heterozygote) (No Gene Mutation)

Partner:

The Male Partner

Last _____ First _____

Date of Birth 19__ __ __ Genetically Affected; a "Carrier"; a "Noncarrier"
Year Month Day (Has Gene Mutation) (Heterozygote) (No Gene Mutation)

Affected Relative:

If Any

Last _____ First _____

Date of Birth _____ Relationship to Patient _____
Year Month Day (Son, Sister, Mother, Aunt, Nephew..... with this Genetic Disorder)

Genetic Disorder of Concern:

e.g. Cystic Fibrosis, Fragile X

Patient Address:

Street Address _____

City _____ State _____ Zip _____

Phone:

_____ Home _____ Work _____ Mobile (This is important on testing day)

Best Email:

Patient/Partner

VERY important for us to interact with you and coordinate your care with your IVF doctors

Today's Date:

IVF Clinic Name:

IVF-Endocrinologist-Physician Name (primary):

IVF Coordinator with whom we can communicate:

Clinic Contact Phone:

_____ - _____ - _____ Ext _____

Please fax this form and the DNA diagnostic report(s) that define the gene mutation (if you have it) to us at 313-544-4006. Call us at 313-579-9650 if you have any questions.

Genesis Genetics Institute considers this information to be private and confidential under HIPAA guidelines.