# Endometrial Receptivity Analysis Physician's Request for Genetic Consultation Form

**Please fill out patient and clinic information, and any additional information that could facilitate our discussion with your patient. This form can be emailed to gcusa@igenomix.com. A member of our genetic counseling team will contact your patient. An appointment should be available within one week of your request.**

## PATIENT INFORMATION

Patient Last Name: _____ First: _____ Middle: _____ Birthdate: _____

Partner Last Name: _____ First: _____ Middle: _____ Birthdate: _____

Phone Number: _____ E-mail address: _____

## CLINIC INFORMATION

Name of IVF Clinic: _____

Referring Physician: _____Signature: _____

Primary Nurse: _____E-mail (to send genetic counseling note):_____

## OPTIONAL INFORMATION

### REASON FOR GENETIC COUNSELING REFERRAL

- ☐ Pre-test Overview and Informed Consent
- ☐ Post-test Review of Results
- ☐ Patient Requested
- ☐ Specific Questions/Topics to be Discussed: _____

### REASON FOR ERA TESTING

- ☐ Implantation Failure (Number of cycles: ____)
- ☐ Endometrial Study
- ☐ Patient Requested
- ☐ Other: _____

### CLINICAL DATA

ERA Cycle type:

- ☐ Hormone replacement therapy (HRT), monitoring progesterone (e.g. P+5)
- ☐ Natural cycle, monitoring LH surge (e.g. LH+7)
- ☐ Natural cycle, monitoring follicle rupture (e.g. ultrasound +8)

Pregnancy history:

- ☐ Patient has never been pregnant before
- ☐ Patient has been pregnant before (number of pregnancies:___)
- ☐ Patient has had only biochemical pregnancies (number of biochemical pregnancies: ___)

Other relevant information: _____

- ☐ Urgent. Please explain: _____
- ☐ I would like an ERA specialist to reach out to me to discuss Igenomix's ERA protocol recommendations. *

Phone number: _____

*Igenomix may reach out to the physician if the patient requests medical advice from the genetic counselor.