igenomix
PIONEERS IN REPRODUCTIVE GENETICS

Pioneers in Reproductive Medicine and Genetics

Endometrial Receptivity Analysis (ERA) Requisition Form

CONTACT AND ORGANIZATION INFORMATION Date: ____________________

Organization: ____________________

Street Address: ____________________

City, State, Zip Code: ____________________

Primary Contact Person: ____________________ Email: ____________________ Phone Number: ____________

Referring Provider: ____________________

Referring Provider Signature: ____________________
(Physician signature implies that he/she has counseled the patient about all possible testing outcomes)

Changes to Contact Information: ____________________

PATIENT INFORMATION

Patient Last Name: ____________________ First: ____________________ Middle: ____________

DOB: ____________ Race (optional): ____________ BMI (optional): ____________ MRN: ____________

Street Address: ____________________

City, State Zip Code: ____________________

Phone Number: ____________________ Email address: ____________________

SAMPLE INFORMATION

Cycle type:
Natural, LH+ _______ (days after LH surge, eg.: LH+7). Indicate LH surge day: ____________
Ultrasound+ _________ (days after follicle rupture, eg.: Ultrasound+6)
Hormone Replacement Therapy, Progesterone+ _______ (days after progesterone, eg.: P+5)
Date ____________________ and time ________________ for the first intake of Progesterone
☐ 1st biopsy from this patient ☐ 2nd biopsy from this patient ☐ Other

Method:
☐ Curette
☐ Pipelle
☐ Other: ____________
Biopsy Info:
Date: ____________
Time: ____________

CLINICAL DATA

☐ Endometrium study ☐ Implantation failure (please indicate number of cycles: _________)

Summarized medical history or relevant background: ____________________

PAYMENT METHOD (SELECT ONE):

☐ Clinic Bill
☐ Patient Bill
Credit Card: ☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover Date: ____________________
Card Number: ____________________ CVV2 Code: ____________ Expiration date: _______
Cardholder Name: ____________________
Cardholder Street Address (if different from above): ____________________
City, State, Zip Code: ____________________

Patient Financial Responsibility:
By signing, I authorize Igenomix to charge my credit card the total fee for this test. Signature: ____________________

Office use only: Sample#:_______________ Date received: _______

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