Clinic Enrolment Form

Clinic Information

Date: _____

Name: _____

Address: _____

City: _____ Country: _____ Postcode: _____

Telephone: _____

Email – Administration: _____ VAT Registration No: _____

Opening hours (Monday to Friday): _____ Opening hours (Weekend): _____

Additional information for sample collection: _____

Emergency phone number: _____

Referring Clinician/Staff Information

Position	Name	Email
Medical Director		
IVF Clinician 1		
IVF Clinician 2		
IVF Clinician 3		
IVF Clinician 4		
Senior Nurse		
Senior Embryologist		
Genetic Counsellor		

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Accounts & Billing Information

Please invoice to: ☐ Clinic ☐ Patient

Accounts & billing contact person:_____

Telephone:_____ Email:_____

Sample Arrival Notification

Please send notification of sample receipt at Igenomix to the following contacts:

Name	Email

Test Reporting

Reports should be sent to (select **one**):

☐ **Only** the email address(es) provided on the test requisition form

☐ The email address(es) provided on the test requisition form **and** the following email address(es):

Name	Email

☐ **Other instruction** – please specify:

Additional Information

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