

## 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

Accounts & billing contact at clinic (invoice recipient): \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

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## Sample Arrival Notification

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

Name	Email

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## 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:

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## Additional Information