



## GENETIC SCREENING WAIVER

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(Print Partner's full name)

As part of the infertility treatment my physician has recommended Genetic Testing to determine if I am a carrier. My initials below represent whether or not I wish to have the testing performed as part of my treatment plan. I understand I can proceed with infertility treatment without the Genetic Testing.

Recommended Genetic Test Panel: Universal Genetic Test (100+ disease screen)

Initial your choice below:

\_\_\_\_\_ I agree to the above test and understand there is additional cost involved that I will incur.

\_\_\_\_\_ I decline the above test.

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Partner Signature

Date

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Physician Signature

Date

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Witness Signature

Date