GENETIC TESTING PROGRAM REQUISITION FORM

Blueprint Genetics

Resonate Program for Auditory Neuropathy

Promotion/Contract Code: **AKOUOS-HL**

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Marlborough, MA 01752
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support.us@blueprintgenetics.com (US)

See test codes and detailed descriptions on tests on **blueprintgenetics.com**

REQUIRED FIELDS ARE MARKED WITH AN ASTERISK (*)

***TEST CODE**

E	A	0	6	0	1

TEST INFORMATION

*** Test Name:** Resonate Program Panel

All tests include analysis of both small exonic and splice site variations, and large deletions and insertions.

Sample type[ii]: ☐ **Blood** ☐ **Saliva** ☐ **DNA, source:**	**Sample Collection Date:**

ii) Please note that this information affects interpretation for mitochondrial DNA testing.
More information about sample requirements on blueprintgenetics.com/sample-requirements.

PROGRAM-SPECIFIC INFORMATION

Eligibility Criteria

Eligibility for this program is a current or prior clinical diagnosis of auditory neuropathy, or a medical history consistent with auditory neuropathy. Auditory neuropathy (AN) is a hearing disorder characterized by an absent or abnormal auditory brainstem response (ABR) with preservation of otoacoustic emissions (OAEs) or cochlear microphonics (CMs).

Question 1:

1a. OAE or CM present with absent or abnormal ABR:

Yes ☐ **No** ☐

1b. OAE or CM previously present with absent or abnormal ABR:

Yes ☐ **No** ☐

Question 2:

Patient does not have evidence of syndromic medical history:

Yes ☐ **No** ☐

Genetic Counseling

Select one of the options

☐ My institute will provide genetic counseling for the patient

☐ I request for my patient post-test genetic counseling service offered by the genetic testing program

ORDERING HEALTH CARE PROFESSIONAL INFORMATION

*** Name and Full Address:**	*** Institution:**	
	*** Email:**	
	*** NPI# (REQUIRED, US only):**	
	Phone:	**Fax:**

Delivery of results ☐ **Mail** ☐ **Fax** ☑ **Nucleus** Results will always be available on our online reporting system at nucleus.blueprintgenetics.com.

SHARE RESULTS WITH

Name:		**Role/Title:**	
Email:		**Street Address:**	
City:	**State:**	**Zip/Post Code:**	**Country:**
Phone:	**Fax:**	☐ **Mail Results** ☐ **Fax Results** ☐ **Nucleus**	Results can be shared within the same hospital on our ordering portal, Nucleus.

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PATIENT INFORMATION

*** First Name:**		*** Last Name:**	
*** DOB: Year / Month / Day**		**MRN/SSN:**	
Street Address:			
City:	**State:**	**Zip/Post Code:**	**Country:**
Phone:	**Email:**		

PATIENT HISTORY

*** Sex:** ☐ Male ☐ Female ☐ Unknown/ uncertain	**Ethnicity:**	**ICD-10 Codes:**
*** Has the Patient Received a Hematopoietic Stem Cell Transplantation?** ☐ Yes ☐ No		
*** Has the Patient Received Granulocyte Transfusions in the Past Two Weeks?** ☐ Yes ☐ No		
*** Describe the Relevant Clinical Findings Supporting the Diagnosis** (attach possible supportive material such as ECG):		

Family History (attach pedigree if available):	**Previous Genetic Testing Results:**

VARIANT SPECIFIC TESTING INFORMATION

REQUIRED FIELDS ARE MARKED WITH AN ASTERISK (*)

Please select either Familial Variant Testing or Targeted Variant Testing

☐ **Familial Variant Testing** Select this test when you want to test your patient for a variant that has been found in one of their relatives.	☐ **Targeted Variant Testing** Select this test for founder mutation testing, confirmation of research results or clarifications of variant interpretation from another laboratory.
*** Index Patient's Order ID:** *** Index Patient's Subject ID:**	*** Indication for testing:** ☐ **Confirmation of research results** ☐ **Clarifying interpretation** ☐ **Founder/common mutation** ☐ **Other: Study**
*** Indication for testing** ☐ **Diagnostic** ☐ **Predictive** ☐ **Carrier** ☐ **Segregation** ☐ **Other: Study**	
*** Complete the following sentence to explain the relationship between the person being tested and the index patient. The person being tested is the index patient's:** (e.g. son, daughter, brother, sister, mother, father)	

VARIANTS TO BE TESTED

	***Gene:** (e.g. LMNA)	***Transcript:** (e.g. NM_170707.3)	***cDNA change:** (e.g. c.4375C>T or c.612_615del)	***Protein change:** (e.g. Arg190Gln)
***Variant 1:**				
Variant 2:				
Variant 3:				

* BILLING INFORMATION

☐ **INSTITUTIONAL BILLING**

Facility Name: Akouos	
Street Address: 645 Summer Street Suite 200	**City:** Boston **State:** MA **Zip/Post Code:** 02210
Country:	**Contact Person:**
Phone:	**Email:**

GENERAL TERMS

By placing the order the Customer accepts Blueprint Genetics' General Terms. Blueprint Genetics reserves the right to amend its General Terms, of which the latest version shall always be applied. The latest version can be found at https://blueprintgenetics.com/general-terms/

ORDERING HEALTH CARE PROFESSIONAL SIGNATURE

I have discussed and obtained the Genetic Testing Program Informed Consent with the patient or their legal guardian and obtained any other consent from the patient that is required under the laws of my country/Province and local laws. I will maintain a record of the consent(s) and promptly notify Blueprint Genetics in writing of any changes, including revocation, of a consent. I certify that the patient is eligible and suitable for genetic testing services and/or genetic counseling I am ordering under the program. I agree I will not bill the patient or their insurance for the genetic testing services and/or genetic counseling offered as part of this program. I authorize Blueprint Genetics, and others working with Blueprint Genetics to contact me by mail, email or phone to inform me about ongoing clinical trials, clinical studies, services and products that might be relevant to the patient. I understand that I may revoke this authorization by contacting Blueprint Genetics Client Services.

*** Signature:**	*** Date:**
*** Name:**	

HEALTH CARE PROFESSIONAL SIGNATURE REQUIRED FOR PROCESSING