TEST REQUISITION FORM

Blueprint Genetics

This requisition form, and consent forms in other languages, can be printed from **blueprintgenetics.com**

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Promotion/Contract Code: .....

See test codes and detailed desciptions on tests and analysis types on **blueprintgenetics.com**

REQUIRED FIELDS ARE MARKED WITH AN ASTERISK (*)

***TEST CODE**

*** Test Name:**	☐ **Family Extension Service**[i]
*** Analysis Type:** ☐ **Sequence Analysis** ☐ **Del/Dup Analysis** ☐ **Plus Analysis** (Seq and Del/Dup) ☐ **Family member testing**	
Sample Type: ☐ **Blood** ☐ **Saliva** ☐ **DNA, source:**	**Sample Collection Date:**

[i] Check eligibility for this service on our website blueprintgenetics.com/family-extension-service

ADDITIONAL TEST INFORMATION

Previously tested at Blueprint Genetics: ☐	**Specify the previous order ID:**		You will be contacted if new sample is needed.
Prenatal: ☐ [i]	**Ongoing pregnancy in the family** ☐	**Gestational age:**	i) We do not offer a maternal cell contamination (MCC) test at the moment. We offer prenatal testing only for cases where the maternal cell contamination studies (MCC) are done by another genetic laboratory.
In case of prenatal/ongoing pregnancy, have other family members been tested at Blueprint? If so, specify the order ID's:			
Keep the sample on hold: ☐ **Specify the reason:**			We can store the sample for maximum of 6 months.
Additional information eg. gene masking requests			
In case of gene masking, reflex to full panel if negative: ☐			

ORDERING HEALTH CARE PROFESSIONAL INFORMATION

*** Name and Full Address:**	*** Institution:**	
	*** Email:**	
	NPI# (US only):	
	Phone:	**Fax:**
Delivery of results ☐ **Mail** ☐ **Fax** ☑ **Nucleus** Results will always be available on our online ordering and reporting system, Nucleus at nucleus.blueprintgenetics.com.		

SHARE RESULTS WITH

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

PATIENT INFORMATION

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

PATIENT HISTORY

*** Sex:** ☐ Male ☐ Female ☐ Unknown/ uncertain	**Ethnicity:**	*** ICD-10 Codes:** (for patient insurance – US only)
*** Indication for Testing:** ☐ Diagnostic ☐ Family History ☐ Other:		
Has the Patient Died? ☐ Yes ☐ No	**Hospital Status:** ☐ Inpatient ☐ Outpatient ☐ Non-hospital patient	
*** 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:**

FMT TEST INFORMATION

When ordering a family member test, fill in the following information:

*** Indication for testing:** ☐ Diagnostic ☐ Carrier testing ☐ Predictive testing ☐ Prenatal testing ☐ Pre-approved VUS Clarification Service ☐ Other

☐ **Sanger 1 Mutation**	* Gene and Mutation 1:
☐ **Sanger 2 Mutations**	Gene and Mutation 2:
☐ **Sanger 3 Mutations**	Gene and Mutation 3:

Is the individual considered healthy and unaffected? If not, describe the clinical findings: *

Name of Index:	*** Index Order ID:**	*** Relationship to Index:**

* If the index case has not been tested at Blueprint Genetics, please provide DNA sample from known carrier (positive control to ensure high quality mutation analysis)

* BILLING INFORMATION

☐ INSURANCE BILLING Include copy of both sides of the insurance card. The insurance provider usually requests a letter of medical necessity after submission of the claim.	☐ INSTITUTIONAL BILLING		☐ PATIENT PAYMENT	
	Facility Name:		☐ **Check** Payable to Blueprint Genetics (only for US/CAN customers) ☐ **PayPal** ☐ **Bank Transfer** ☐ **Credit Card**	
Insurance Company:	**Street Address:**			
Insurance ID #:				
Group #:	**City:**	**State:**	**Card Number:**	
Patient Relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other	**Zip/Post Code:**	**Country:**	**Expiration Date:**	**CVC:**
	Contact Person:		**Name:**	
Policy Holder Name:			**Amount:**	
	Phone:		**Phone:**	
Policy Holder DOB:	**Fax:**	**Email:**		

INFORMED CONSENT (available on blueprintgenetics.com in other languages)

I confirm that the information below has been explained to me concerning the test:

1. The results of this test may show that I and/or my family members have an inherited disease or are at an increased risk of being affected by a genetic disease. I understand that this test may detect previously unrecognized biological relationships, such as non-paternity.
2. I am aware that the results of this test might be inconclusive about my genetic status. While some genetic variants are known to be disease-causing and others are known to be benign, a portion of genetic variants found are of uncertain significance. Depending on the results of this test, my physician may recommend genetic counseling or further testing of myself and/or my family members.
3. I understand that an anonymized summary of results from this test may be presented, for example, at meetings, in scientific publications, and/or in DNA-variant databases in order to improve the understanding, diagnostics, and treatment of similar clinical conditions. No personal identifying information will ever be presented with the results.
4. If I have selected the patient insurance billing option, I authorize my health plan or insurance provider to pay my insurance benefits directly to Blueprint Genetics. I authorize Blueprint Genetics to release information concerning my testing to my insurer. I understand that I am legally responsible for sending Blueprint Genetics any money received from my insurance company for performance of this genetic test. If my insurance does not cover these services or only covers part of the amount, I am responsible for any remaining costs of this test.
5. I am aware that not consenting to any of the sections to follow will not in any way affect my further treatment. If no box is checked in a section, it is assumed that no consent is given.
6. **Separate consent for sample storage at Blueprint Genetics for 3 years for the purposes of family member testing.** By checking the relevant box below I give my consent to the 3-year storage of the DNA sample in the diagnostic laboratory of Blueprint Genetics for the purposes of family member testing. Without this permission the sample will be stored approximately for 12 months.

   ☐ **I give my consent to the 3-year storage of the sample for family member testing.**
   ☐ **I do not give my consent to the 3-year storage of the sample family member testing.**

7. **Separate consent for research use and long-term storage.** By checking the relevant box below, I give my consent to the long-term storage of the DNA sample in the diagnostic laboratory of Blueprint Genetics (without separate consent for long-term storage the DNA samples are typically stored for approximately 24 months) for use of the DNA sample in research into hereditary Mendelian diseases and the efforts to improve the diagnostics and treatment of said diseases. The research data pertaining to me will be treated as confidential information and coded in such a way that my identity cannot be discovered without the key code in the possession of the Blueprint Genetics research physician. Where necessary, such coded research data may also be processed and released for use by another research group or a company participating in the study. I hereby give my consent to the use of the aforementioned research data for the purposes described in this consent. The data will be preserved for 50 years. I understand that consenting to the research use of the sample taken for diagnostic purposes is voluntary and that I may cancel this consent and withdraw my participation at any time prior to the completion of the study. I am aware that the data collected up to the date of my withdrawal will be used as part of the research material. My refusal to take part in or my decision to withdraw from the research project will not in any way affect my further treatment.

Check one of the following two boxes:

☐ **I give my consent to the research use and long-term storage of the sample as described in Section 7 above.**
☐ **I do not give my consent to the research use and long-term storage of the sample as described in Section 7 above.**

☐ **I give Blueprint Genetics permission to contact me about further genetic research and/or other genetic services relevant to me in the future. I may withdraw from such contact at any time.**

PATIENT SIGNATURE Patient or Legal Representative	By signing this form, I acknowledge that I have read the Informed Consent and understand its content. I have had the opportunity to ask questions about this form and my questions have been answered.	
	Signature:	**Date:**

ORDERING HEALTH CARE PROFESSIONAL SIGNATURE	I have discussed the 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/state and/or federal laws. I certify that the test ordered is medically necessary for the diagnosis or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results of this test will be used in the medical management of the patient and/or genetic counseling of the patient and family member(s). I have read and understood the General Terms of Service.	
	*** Signature:**	*** Date:**

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/