

TEST REQUISITION FORM

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 descriptions on tests and analysis types on blueprintgenetics.com

REQUIRED FIELDS ARE MARKED WITH AN ASTERISK (*)

*TEST CODE

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* Test Name:	<input type="checkbox"/> Family Extension Service ¹⁾
* Analysis Type: <input type="checkbox"/> Sequence Analysis <input type="checkbox"/> Del/Dup Analysis <input type="checkbox"/> Plus Analysis (Seq and Del/Dup) <input type="checkbox"/> Family member testing <input type="checkbox"/> Single gene testing	
Sample Type: <input type="checkbox"/> Blood <input type="checkbox"/> Saliva <input type="checkbox"/> DNA, source:	Sample Collection Date:

¹⁾ Check eligibility for this service on our website blueprintgenetics.com/family-extension-service

ADDITIONAL TEST INFORMATION

Previously tested at Blueprint Genetics: <input type="checkbox"/>	Specify the previous order ID: _____	You will be contacted if new sample is needed.
Prenatal: <input type="checkbox"/> ⁱ⁾	Ongoing pregnancy in the family <input type="checkbox"/>	Gestational age: _____
In case of prenatal/ongoing pregnancy, have other family members been tested at Blueprint? If so, specify the order ID's:		
Additional information:		

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.

ORDERING HEALTH CARE PROFESSIONAL INFORMATION

* Name and Full Address:	* Institution:
	* Email:
	NPI# (US only):
	Phone: _____ Fax: _____
Delivery of results <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input checked="" type="checkbox"/> 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:	<input type="checkbox"/> Mail Results <input type="checkbox"/> Fax Results <input type="checkbox"/> Nucleus Results can be shared within the same hospital on our ordering portal, Nucleus.	

PATIENT INFORMATION

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

PATIENT HISTORY

* Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown/uncertain	Ethnicity:	* ICD-10 Codes: (for patient insurance – US only)
* Indication for Testing: <input type="checkbox"/> Diagnostic <input type="checkbox"/> Family History <input type="checkbox"/> Other:		
Has the Patient Died? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital Status: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-hospital patient	
* Has the Patient Received a Hematopoietic Stem Cell Transplantation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
* Has the Patient Received Granulocyte Transfusions in the Past Two Weeks? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Diagnostic <input type="checkbox"/> Carrier testing <input type="checkbox"/> Predictive testing <input type="checkbox"/> Prenatal testing <input type="checkbox"/> Pre-approved VUS Clarification Service <input type="checkbox"/> Other		
<input type="checkbox"/> Sanger 1 Mutation	* Gene and Mutation 1:	
<input type="checkbox"/> Sanger 2 Mutations	Gene and Mutation 2:	
<input type="checkbox"/> 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:
<small>* 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)</small>		

*** BILLING INFORMATION**

REQUIRED FIELDS ARE MARKED WITH AN ASTERISK (*)

<input type="checkbox"/> 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.	<input type="checkbox"/> INSTITUTIONAL BILLING		<input type="checkbox"/> PATIENT PAYMENT Patient payment is by credit card. The payment process begins with the patient receiving a link with payment details to the email address filled out below. The sample goes to analysis once the payment has been collected by Blueprint Genetics. Please contact billing.us@blueprintgenetics.com or (650) 452-9340 ext 1 if you wish to discuss alternative payment options.
	Facility Name:		
Insurance Company:	Street Address:		
Insurance ID #:			
Group #:	City:	State:	Email:
Patient Relation to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Zip/Post Code:	Country:	
Policy Holder Name:	Contact Person:		Name:
Policy Holder DOB:	Phone:	Fax:	Phone:

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:
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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/>

HEALTH CARE PROFESSIONAL SIGNATURE REQUIRED FOR PROCESSING

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 12 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.

- 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.

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- 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

<p>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.</p>	
<p>Patient name (please print):</p>	<p>Date:</p>
<p>Patient signature:</p>	<p>Signature of Legal Representative, if patient is a minor:</p>
<p>Name and relationship of Legal Representative, if patient is a minor (please print):</p>	