Blueprint Genetics

TEST REQUISITION FORM

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

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support@blueprintgenetics.com
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support.us@blueprintgenetics.com (US)
support.ca@blueprintgenetics.com (CAN)

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**

TEST INFORMATION

*** Test Name:**

*** Choose Test and Analysis Type**

☐ **Panel**	**Analysis Type:**	☐ **Sequence Analysis**	☐ **Plus Analysis** (Seq and Del/Dup)	☐ **Del/Dup Analysis**
☐ **Single gene**	**Analysis Type:**	☑ **Plus Analysis** (Seq and Del/Dup)		
☐ **Variant Specific Testing** (Familial Variant Testing / Targeted Variant Testing)				

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

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:			
Additional information:			

ORDERING HEALTH CARE PROFESSIONAL INFORMATION

*** Name and Full Address:**	*** Institution:**
	*** Email:**
	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.

PATIENT INFORMATION

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

REQUIRED FIELDS ARE MARKED WITH AN ASTERISK (*)

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:**	

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 clarification of variant interpretation from another laboratory.

*** Was the index patient tested at Blueprint Genetics?**

☐ **Yes**

*** Blueprint Genetics Order ID:**

*** Index Patient's Name:**

*** Index Patient's Date of Birth:**

☐ **No / Not known**

*** Indication for testing:**

☐ **Confirmation of research results**

☐ **Clarifying interpretation**

☐ **Founder/common mutation**

☐ **Other:**

*** Indication for testing**

☐ **Diagnostic** ☐ **Predictive** ☐ **Carrier** ☐ **Segregation**

☐ **Other:**

*** 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)

*** Is the person being tested healthy and unaffected?** If not, describe the clinical findings:

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:				
Variant 4:				
Variant 5:				
Variant 6:				
Variant 7:				
Variant 8:				
Variant 9:				
Variant 10:				

REQUIRED FIELDS ARE MARKED WITH AN ASTERISK (*)

* BILLING INFORMATION

<table>
<tr><td colspan="2">☐ 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.</td><td colspan="2">☐ INSTITUTIONAL BILLING
Facility Name:</td><td rowspan="2">☐ 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 note that we accept Visa and Mastercard.

Please contact support@blueprintgenetics.com if you wish to discuss alternative payment options.</td></tr>
<tr><td colspan="2">Insurance Company:

Insurance ID #:</td><td colspan="2">Street Address:</td></tr>
<tr><td>Group #:</td><td>City:</td><td>State:</td><td rowspan="2">Email:</td></tr>
<tr><td>Patient Relation to Policy Holder:
☐ Self ☐ Spouse ☐ Child ☐ Other</td><td>Zip/Post Code:</td><td>Country:</td></tr>
<tr><td>Policy Holder Name:</td><td colspan="2">Contact Person:</td><td>Name:</td></tr>
<tr><td>Policy Holder DOB:</td><td>Phone:</td><td>Fax:</td><td>Phone:</td></tr>
</table>

ORDERING HEALTH CARE PROFESSIONAL SIGNATURE

<table>
<tr><td colspan="2">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.</td></tr>
<tr><td>* Signature:</td><td>* Date:</td></tr>
</table>

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.**

☐ **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

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