Blueprint Genetics

TEST REQUISITION FORM

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

Phone (US): +1 650 452 9340
Phone (CAN): +1 833 697 4665
Fax: + 1 650 446 7790
support.us@blueprintgenetics.com (US)
support.ca@blueprintgenetics.com (CAN)

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support@blueprintgenetics.com

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

REQUIRED FIELDS ARE MARKED WITH AN ASTERISK (*)

***TEST CODE** | | | | | | |

Promotion/Contract Code: .....

TEST INFORMATION

*** Test Name:**

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

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

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

ADDITIONAL TEST INFORMATION

Previously tested at Blueprint Genetics: ☐	**Specify the previous order ID:**	You will be contacted if new sample is needed.
Is this a fetal sample? ☐ ii)	**Is this sample from an ongoing pregnancy?** ☐	ii) 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.
Ongoing pregnancy in the family ☐	**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:		

ORDERING HEALTH CARE PROFESSIONAL INFORMATION

***Name:**		***Institution:**
***Street Address:**		***Email:**
***City:**	**State:**	**Phone:**
***Zip/Post Code:**	***Country:**	**Fax:**
Delivery of results ☐ **Mail** ☐ **Fax** ☑ **Nucleus**	Results will always be available on our online reporting system at nucleus.blueprintgenetics.com.	

SHARE RESULTS WITH A COLLEAGUE

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

To enable processing, provide at least two unique patient identifiers that match those on the sample label (we recommend using the patient's full name: first & last name and date of birth).

*** First Name:**	*** Last Name:**
*** DOB:** Year / Month / Day	**Patient Identifier/MRN:**

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CLINICAL HISTORY

*** Sex:** ☐ Male ☐ Female ☐ Unknown/uncertain	**Ethnicity:**
*** Has the patient received a hematopoietic stem cell transplantation?** ☐ Yes ☐ No	
*** Has the patient received granulocyte transfusions in the past two weeks?** ☐ Yes ☐ No	
*** Indication for testing:** ☐ Diagnosis ☐ Family History ☐ Other:	
ICD-10 Codes: (for patient insurance – US only)	
Hospital Status: ☐ Inpatient ☐ Outpatient ☐ Non-hospital patient	
Age of Primary Diagnosis:	
Has the patient died? ☐ Yes ☐ No **When?**	
Affected family members: ☐ Yes ☐ No **Who and what symptoms?**	
Previous genetic tests: ☐ Yes ☐ No **Specify test and results:**	
*** Describe the most relevant clinical findings supporting the diagnosis** (attach possible supportive material such as ECG):	

FILL THIS PAGE ONLY IF ORDERING VARIANT SPECIFIC TESTING

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.

*** Indication for testing:**

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

☐ **Other:**

*** 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**

*** Is the person being tested healthy and unaffected?**

If not, describe the clinical findings:

Clinical features of the individual and other relevant information for the geneticists:

*** 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)

TARGETED VARIANT TESTING

☐ Select this test for founder mutation testing, confirmation of research results or clarification of variant interpretation from another laboratory.

*** Indication for testing:**

☐ **Confirmation of research results** ☐ **Clarifying interpretation**

☐ **Founder/common mutation**

☐ **Other:**

Clinical features of the individual and other relevant information for the geneticists:

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:				

* BILLING INFORMATION

Please select **either** Institutional Billing **or** Patient Payment

☐ **INSTITUTIONAL BILLING** Please provide all details below if ordering for the first time or billing different than usual institution for this order.	
Facility Name:	
Street Address:	
City:	**State:**
Zip/Post Code:	**Country:**
Contact Person:	
Phone:	**Email:**

☐ **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.
*** Email:**
*** Name:**
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 Blueprint Genetics' General Terms of Service, as currently posted at https://blueprintgenetics.com/general-terms/. Unless there is a written agreement between the Institution and Blueprint Genetics, I accept, and have the authority to accept, these General Terms of Service on behalf of the Institution.	
*** Signature:**	
*** Name:**	*** Date (YYYY-MM-DD):**

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 to be 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, scientific publications and/or DNA variant databases in order to improve the understanding, diagnostics and treatment of similar clinical conditions. No identifying information will ever be presented.
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 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 and it is disposed of after that unless earlier disposal is required by applicable laws.

   ☐ I give my consent to the 3-year storage of the sample for 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 concerning 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 within or outside the European Union 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 set out in this consent. The data will be preserved for 50 years.

   I understand that my consent 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.

   ☐ I give my consent to the research use and long-term storage of the sample as set out in Section 7 above.

More information about how we process personal data: https://blueprintgenetics.com/privacy/

☐ **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):	Patient date of birth (YYYY-MM-DD):
Patient signature:	Date (YYYY-MM-DD):
Name and relationship of Legal Representative, if patient is a minor (please print):	Signature of Legal Representative, if patient is a minor: