

GENEAWARE REQUISITION

Patient Last Name Patient First Name MI Date of Birth (MM / DD / YYYY) Biological Sex

ETHNICITY

African American Hispanic American Pacific Islander (Philippines, Micronesia, Malaysia, Indonesia)
 Ashkenazi Jewish Mennonite South Asian (India, Pakistan)
 East Asian (China, Japan, Korea) Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey) Southeast Asian (Vietnam, Cambodia, Thailand)
 Finnish Native American Southern European Caucasian (Spain, Italy, Greece)
 French Canadian Northern European Caucasian (Scandinavian, UK, Germany) Other (Specify): _____

SAMPLE

Date of Collection (MM / DD / YYYY) _____ / _____ / _____

SAMPLE TYPE

Blood (Collected in 4 cc EDTA tube with GeneAware barcode)*
 Saliva (Collected in GeneAware kit)
 Buccal Swab (Collected in GeneAware kit)

CARRIER TESTING PANELS

FEMALE 60401 Basic 60101 Complete (version 2)
 60301 ACMG and ACOG 64000 Comprehensive (version 3.3)
 60201 Ashkenazi Jewish

MALE 60406 Basic 60106 Complete (version 2)
 60306 ACMG and ACOG 64005 Comprehensive (version 3.3)
 60206 Ashkenazi Jewish

INDICATION FOR CARRIER TESTING (REQUIRED)

No Family History Male Infertility / Female Infertility
 Patient Known Carrier * Family History of Consanguinity
 Partner Known Carrier * Egg / Sperm Donor
 Known Family History * (Specify relationship) Abnormal Fetal Ultrasound (Specify)

* Please provide the below information and attach report, if applicable.

Disease

Gene Variant

Is Patient or Patient's Partner Currently Pregnant?
Testing is not available to minors, unless pregnant. Yes No

If Yes, please specify Gestational Age:
 LMP _____ / _____ / _____ U/S _____ / _____ / _____
 MM DD YYYY MM DD YYYY

Gestational Age on U/S Date: _____ _____
 Weeks Days

ICD10 Diagnosis Code(s): _____

MERGED COUPLE REPORTS FOR GENEAWARE PANELS

NOTE: If an individual's sample is submitted after their partner's sample has already been submitted, and the couple wishes to have a merged report, both results will be held until all testing is completed in order to produce a merged report. This may cause the couple's merged report to be sent out longer than 14 days from the first sample submitted, but within 14 days of the second sample submitted.

Partner Last Name Partner First Name

MI Date of Birth (MM / DD / YYYY) Couple Sent Together
 Partner Sent Previously

Baylor Lab # Family #

By agreeing to this informed consent, you provide authorization for your results to be disclosed to your ordering physician and other covered entities. If both you and your partner are being tested simultaneously or if your results are subsequently merged, you are authorizing the release of your results to your partner's healthcare provider, which may include sensitive medical information. Your results may become part of your partner's medical record, which is available to your partner's physician and other covered entities.

IF NOT SIGNED, SEPARATE REPORTS WILL BE ISSUED

Patient Name Date of Birth (MM / DD / YYYY)

Patient Signature Date (MM / DD / YYYY)

Partner Name Date of Birth (MM / DD / YYYY)

Partner Signature Date (MM / DD / YYYY)

NEW YORK STATE PHYSICIAN SIGNATURE OF CONSENT

I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested. I have answered this person's questions. I have obtained informed consent from the patient or their legal guardian for this testing.

Physician's Printed Name Physician's Signature Date (MM / DD / YYYY)

