BAYLOR GENETICS

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
GRAND BLVD. RECEIVING DOCK
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

TOTAL BLUEPRINT PANEL REQUISITION

PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

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

Address | City | State | Zip | Phone

Accession # | Hospital / Medical Record #

Patient discharged from the hospital/facility: ◯ Yes ◯ No

Biological Sex: ◯ Female ◯ Male ◯ Unknown

Gender identity (if different from above):

REPORTING RECIPIENTS

Ordering Physician | Institution Name

Email (Required for International Clients) | Phone | Fax

ADDITIONAL RECIPIENTS

Name | Email | Fax

Name | Email | Fax

PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

◯ **SELF PAYMENT**

☐ Pay With Sample ☐ Bill To Patient

◯ **INSTITUTIONAL BILLING**

Institution Name | Institution Code | Institution Contact Name | Institution Phone | Institution Contact Email

◯ **INSURANCE**

☐ Do Not Perform Test Until Patient is Aware of Out-Of-Pocket Costs (excludes prenatal testing)

REQUIRED ITEMS 1. Copy of the Front/Back of Insurance Card(s) 2. ICD10 Diagnosis Code(s) 3. Name of Ordering Physician 4. Insured Signature of Authorization

Name of Insured | Insured Date of Birth (MM / DD / YYYY)

Patient's Relationship to Insured | Phone of Insured

Address of Insured

City | State | Zip

Primary Insurance Co. Name | Primary Insurance Co. Phone

Primary Member Policy # | Primary Member Group #

Name of Insured | Insured Date of Birth (MM / DD / YYYY)

Patient's Relationship to Insured | Phone of Insured

Address of Insured

City | State | Zip

Secondary Insurance Co. Name | Secondary Insurance Co. Phone

Secondary Member Policy # | Secondary Member Group #

By signing below, I hereby authorize Baylor Genetics to provide my insurance carrier any information necessary, including test results, for processing my insurance claim. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates, as well as any amounts not paid by my insurance carrier for reasons including, but not limited to, non-covered and non-authorized services. I understand that I am responsible for sending Baylor Genetics any and all payments that I receive directly from my insurance company in payment for this test. Please note that Medicare does not cover routine screening tests.

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

STATEMENT OF MEDICAL NECESSITY (REQUIRED)

This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

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

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ETHNICITY

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

TEST OPTION

● 1390 Total BluePrint Panel

INDICATION FOR TESTING (REQUIRED)

ICD10 Diagnosis Code(s)

SAMPLE

SAMPLE TYPE

- ◯ Blood
- ◯ Cord Blood
- ◯ Cultured Skin Fibroblast
- ◯ Extracted DNA from: _____

Date of Collection: ____ / ____ / ____ (MM / DD / YYYY)

NOTE: Extracted DNA/RNA will only be accepted if the isolation of nucleic acids for clinical testing occurs in a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by the CAP and/or the CMS.

BIOLOGICAL PARENTS INFORMATION

BIOLOGICAL PARENTS SAMPLES are requested for Total BluePrint Panel interpretation of child. Send 10 cc blood in EDTA tube or saliva sample. Be sure to label parental samples with full name and parental date of birth - DO NOT LABEL WITH CHILD'S NAME. Must sign parental testing authorization on consent.

1505 | MATERNAL INFORMATION

☐ Asymptomatic ☐ Symptomatic (Attach summary of findings)

Maternal Last Name

Maternal First Name | MI

Maternal Date of Birth: ____ / ____ / ____ (MM / DD / YYYY)

Sample Type: ◯ Blood ◯ Saliva

Date of Collection: ____ / ____ / ____ (MM / DD / YYYY)

☐ Not Available ☐ To Be Sent Later *

1505 | PATERNAL INFORMATION

☐ Asymptomatic ☐ Symptomatic (Attach summary of findings)

Paternal Last Name

Paternal First Name | MI

Paternal Date of Birth: ____ / ____ / ____ (MM / DD / YYYY)

Sample Type: ◯ Blood ◯ Saliva

Date of Collection: ____ / ____ / ____ (MM / DD / YYYY)

☐ Not Available ☐ To Be Sent Later *

1506 | OTHER RELATIVE OF PROBAND

Prior to submitting samples from a relative other than the parents, please call the lab at 713.798.6555 to obtain approval. Must sign other relative testing authorization on consent.

☐ Asymptomatic ☐ Symptomatic (Attach summary of findings)

Last Name

First Name

Relationship to Proband

Date of Birth: ____ / ____ / ____ (MM / DD / YYYY)

Biological Sex: _____

Sample Type: ◯ Blood ◯ Saliva

Date of Collection: ____ / ____ / ____ (MM / DD / YYYY)

☐ To Be Sent Later *

Approval Received from:

Name of Baylor Genetics Genetic Counselor

Date : ____ / ____ / ____ (MM / DD / YYYY)

* If parent/other relative samples are to be sent later, please include copy of this requisition form with those samples. Please send parent/relative samples within 2 weeks of the child/proband's sample. Additional charges may apply if parent/relative sample are received after the child/proband's sample.

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ITEM CHECKLIST FOR TESTING

- ☐ Proband Sample (EDTA Required)
- ☐ Requisition
- ☐ Indication for Study
- ☐ Signed Total BluePrint Panel Consent Form
- ☐ Clinical Note/Summary
- ☐ Pedigree
- ☐ Maternal Sample (EDTA or Saliva)
- ☐ Paternal Sample (EDTA or Saliva)
- ☐ Other Relative's Sample (EDTA or Saliva)
  Must be approved by the lab before sending

INDICATION FOR TESTING (REQUIRED)

Please provide the following clinical information regarding the patient to be tested. Please also submit a clinic note and pedigree, if available. Phenotypes listed are in HPO terms with the corresponding HPO number (http://human-phenotype-ontology.github.io/). This information is needed to facilitate interpretation of Total BluePrint Panel results. If the laboratory requires additional information, please indicate the health care provider to be contacted:

Physician Name | Physician Phone

PRE/PERINATAL HISTORY

- ☐ 0001622 Prematurity - GA at birth _____
- ☐ 0001511 Intrauterine Growth Restrictions
- ☐ 0001562 Oligohydramnios
- ☐ 0001561 Polyhydramnios
- ☐ 0000476 Cystic Hygroma
- ☐ 0000776 Congenital Diaphragmatic Hernia
- ☐ 0001508 Failure to Thrive
- ☐ 0001539 Omphalocele
- ☐ 0002084 Encephalocele
- ☐ 0010880 Increased Nuchal Translucency
- ☐ _____

EYE DEFECTS & VISION

- ☐ 0000505 Visual Impairment
- ☐ 0000618 Blindness
- ☐ 0000589 Coloboma
- ☐ 0000526 Aniridia
- ☐ 0000528 Anophthalmia
- ☐ 0000568 Microphthalmia
- ☐ 0000508 Ptosis
- ☐ 0000486 Strabismus
- ☐ 0000519 Cataract Congenital Bilateral
- ☐ _____
- ☐ _____

MOTOR/COGNITIVE DEVELOPMENT

- ☐ 0000750 Delayed Speech & Language Development
- ☐ 0001270 Delayed Motor Milestones
- ☐ 0002376 Developmental Regression
- ☐ Intellectual Disability
  - ☐ 0001256 Mild
  - ☐ 0002342 Moderate
  - ☐ 0010864 Severe
- ☐ 0000729 Autistic Spectrum Disorder
- ☐ _____
- ☐ _____

STRUCTURAL BRAIN ABNORMALITIES

- ☐ 0001360 Holoprosencephaly
- ☐ 0001339 Lissencephaly
- ☐ 0002084 Encephalocele
- ☐ 0000238 Hydrocephalus
- ☐ 0002119 Ventriculomegaly
- ☐ 0001273 Abnormality of Corpus Callosum
- ☐ 0002539 Cortical Dysplasia
- ☐ 0012444 Brain Atrophy
- ☐ 0002352 Leukoencephalopathy
- ☐ 0002269 Abnormality of Neuronal Migration
- ☐ 0002126 Polymicrogyria
- ☐ 0001302 Pachgyria
- ☐ 0002500 Abnormality of Cerebral White Matter
- ☐ 0007266 Cerebral Dysmyelination
- ☐ 0006808 Cerebral Hypomyelination
- ☐ 0002134 Abnormality of the Basal Ganglia
- ☐ 0002363 Abnormality of the Brainstem
- ☐ 0007360 Aplasia/Hypoplasia of the Cerebellum
- ☐ 0006817 Aplasia/Hypoplasia of the Cerebellar Vermis
- ☐ _____

NEUROLOGICAL

- ☐ 0001284 Areflexia
- ☐ 0200134 Epileptic Encephalopathy
- ☐ 0001250 Seizures
  - ☐ 0002373 Febrile Seizures
  - ☐ 0012469 Infantile Spasms
  - ☐ 0002123 Generalized Myoclonic Seizures
  - ☐ 0002069 Generalized Tonic-clonic Seizures
  - ☐ 0010818 Generalized Tonic Seizures
  - ☐ 0010819 Atonic Seizures
  - ☐ 0002121 Absence Seizures
  - ☐ 0011169 Generalized Clonic Seizures
  - ☐ 0001251 Ataxia
  - ☐ 0001332 Dystonia
  - ☐ 0002072 Chorea
  - ☐ 0001257 Spasticity
  - ☐ 0009830 Neuropathy
- ☐ _____
- ☐ _____

CRANIOFACIAL

- ☐ 0000256 Macrocephaly
- ☐ 0000252 Microcephaly
- ☐ 0001363 Craniosynostosis
- ☐ 0000204 Cleft Upper Lip
- ☐ 0000175 Cleft Palate
- ☐ 0000316 Hypertelorism
- ☐ 0000601 Hypotelorism
- ☐ 0008050 Abnormality of the Palpebral Fissures
- ☐ 0000286 Epicanthal Folds
- ☐ 0000288 Abnormality of the Philtrum
- ☐ 0010938 Abnormality of the External Nose
- ☐ _____
- ☐ _____

Indications continued on next page

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INDICATION FOR TESTING (REQUIRED) - CONTINUED

HAIR & SKIN

- ☐ 0000957 Cafe-Au-Lait Spots
- ☐ 0001034 Hypermelanotic Macule
- ☐ 0001010 Hypopigmentation of the Skin
- ☐ 0008066 Abnormal Blistering of the Skin
- ☐ 0008064 Ichthyosis
- ☐ 0000988 Skin Rash
- ☐ 0001581 Recurrent Skin Infections
- ☐ 0005306 Capillary Hemangiomas
- ☐ 0001597 Abnormality of the Nail
- ☐ 0004554 Generalized Hypertrichosis
- ☐ 0001596 Alopecia
- ☐ 0002208 Coarse Hair
- ☐ 0002299 Brittle Hair
- ☐ _____
- ☐ _____

CARDIAC

- ☐ 0001631 Atria Septal Defect
- ☐ 0001629 Ventricular Septal Defect
- ☐ 0001655 Patent Foramen Ovale
- ☐ 0001713 Abnormality of Cardiac Ventricle
- ☐ 0001636 Tetralogy of Fallot
- ☐ 0001680 Coarctation of Aorta
- ☐ 0001647 Bicuspid Aortic Valve
- ☐ 0002616 Aortic Root Dilatation
- ☐ 0001638 Cardiomyopathy
- ☐ 0011675 Arrhythmia
- ☐ _____
- ☐ _____

GENITOURINARY

- ☐ 0000113 Polycystic Kidney Dysplasia
- ☐ 0000107 Renal Cyst
- ☐ 0008738 Partially Duplicated Kidney
- ☐ 0000104 Renal Agenesis
- ☐ 0000085 Horseshoe Kidney
- ☐ 0000069 Abnormality of the Ureter
- ☐ 0000795 Abnormality of the Urethra
- ☐ 0000047 Hypospadias
- ☐ 0000028 Cryptorchidism
- ☐ 0000035 Abnormality of the Testis
- ☐ 0000062 Ambiguous Genitalia
- ☐ _____
- ☐ _____

RESPIRATORY

- ☐ 0002093 Respiratory Insufficiency
- ☐ 0002878 Respiratory Failure
- ☐ 0002104 Apnea
- ☐ 0002791 Hypoventilation
- ☐ 0002883 Hyperventilation
- ☐ 0002788 Recurrent Upper Respiratory Tract Infections
- ☐ _____
- ☐ _____

METABOLIC

- ☐ 0001946 Ketosis
- ☐ 0003074 Hyperglycemia
- ☐ 0001943 Hypoglycemia
- ☐ 0001941 Acidosis
- ☐ 0003128 Lactic Acidosis
- ☐ 0003215 Dicarboxylic Aciduria
- ☐ 0002490 Increased CSF lactate
- ☐ 0001992 Organic Aciduria
- ☐ 0030085 Abnormal CSF Lactate Level
- ☐ 00003542 Increased Serum Pyruvate
- ☐ 0003535 3-Methylglutaconic aciduria
- ☐ 0001942 Metabolic acidosis
- ☐ 0100493 Hypoammonemia
- ☐ 0001987 Hyperammonemia
- ☐ 0004923 Hyperphenylalaninemia
- ☐ 0003234 Decreased Plasma Carnitine
- ☐ 0003236 Elevated Serum Creatine Phosphokinase
- ☐ Abnormal Newborn Screen
- ☐ Unusual Color/Odor
- ☐ _____
- ☐ _____

MUSCULOSKELETAL

- ☐ 0011398 Hypotonia
- ☐ 0001276 Hypertonia
- ☐ 0000098 Tall Stature
- ☐ 0004322 Short Stature
- ☐ 0001382 Joint Hypermobility
- ☐ 0001371 Flexion Contracture
- ☐ 0002804 Arthrogryposis Multiplex Congenita
- ☐ 0001161 Hand Polydactly
- ☐ 0001829 Foot Polydactly
- ☐ 0006101 Finger Syndactly
- ☐ 0001770 Toe Syndactly
- ☐ 0100490 Camptodactyly of Finger
- ☐ 0012165 Oligodactyly
- ☐ 0001762 Talipes Equinovarus
- ☐ 0002757 Recurrent Fractures
- ☐ 0002650 Scoliosis
- ☐ 0002808 Kyphosis
- ☐ 0003307 Hyperlordosis
- ☐ 0001528 Hemihypertrophy
- ☐ 0001513 Obesity
- ☐ 0001548 Overgrowth
- ☐ 0002652 Skeletal Dysplasia
- ☐ _____
- ☐ _____

GASTROINTESTINAL

- ☐ 0002021 Pyloric Stenosis
- ☐ 0002575 Tracheoesophogeal Fistula
- ☐ 0002032 Esophageal Atresia
- ☐ 0002020 Gastroesophageal Reflux
- ☐ 0001733 Pancreatitis
- ☐ 0002014 Diarrhea
- ☐ 0002019 Constipation
- ☐ 0002037 Inflammatory Bowel Disease
- ☐ 0004389 Intestinal Pseudo-Obstruction
- ☐ 0001399 Hepatic Failure
- ☐ 0002572 Episodic Vomiting
- ☐ 0001744 Splenomegaly
- ☐ 0002240 Hepatomegaly
- ☐ 0001508 Postnatal Failure to Thrive
- ☐ 0002578 Gastroparesis
- ☐ _____
- ☐ _____

Indications continued on next page

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INDICATION FOR TESTING (REQUIRED) - CONTINUED

HEMATOLOGY

- ☐ 0001875 Neutropenia
  - ☐ 0005549 Congenital
  - ☐ Chronic
  - ☐ Cyclic
- ☐ 0001873 Thrombocytopenia
- ☐ 0040185 Macrothrombocytopenia
- ☐ 0005537 Decreased Mean Platelet Volume
- ☐ 0005518 Erythrocyte Macrocytosis
- ☐ 0004444 Spherocytosis
- ☐ 0012410 Pure Red Cell Aplasia
  - ☐ Aplastic
  - ☐ Hypoplastic
- ☐ 0001903 Anemia
- ☐ 0005528 Bone Marrow Hypocellularity
- ☐ _____
- ☐ _____

CANCER

- ☐ Type of Cancer _____
- ☐ Age of Diagnosis _____
- ☐ Family History of Cancer and Affected Relatives

_____

_____

ENDOCRINE

- ☐ 0000819 Diabetes Mellitus
- ☐ 0000873 Diabetes Insipidus
- ☐ 0000821 Hypothyroidism
- ☐ 0000829 Hypoparathyroidism
- ☐ 0000834 Abnormality of the Adrenal Glands
- ☐ 0001738 Exocrine Pancreatic Insufficiency
- ☐ 0002721 Immunodeficiency
- ☐ _____
- ☐ _____

EAR DEFECTS & HEARING

- ☐ 0000407 Sensorineural Hearing Impairment
  - ☐ 0008619 Bilateral
- ☐ 0000405 Conductive Hearing Impairment
- ☐ 0000410 Mixed Hearing Impairment
- ☐ 0004467 Preauricular Pit
- ☐ 0000384 Preauricular Skin Tag
- ☐ 0000369 Low-set Ears
- ☐ 000037 Abnormality of the Pinna
- ☐ _____
- ☐ _____

OTHER

- ☐ Organomegaly
- ☐ Chronic Infections
- ☐ 0004311 Abnormality of Macrophages
- ☐ 0001954 Episodic Fever
- ☐ 0004313 Hypogammaglobulinemia
- ☐ 0010701 Abnormal Immunoglobulins
- ☐ 0002721 Immunodeficiency
- ☐ _____
- ☐ _____

GENES OF INTEREST

_____

_____

_____

_____

_____

_____

_____

_____

_____

ADDITIONAL CLINICAL INFORMATION

DIFFERENTIAL DIAGNOSIS

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			/ /	

INFORMATION AND CONSENT FOR TESTING

The Total BluePrint Panel is a genetic test to analyze specific genes that may be responsible for causing your clinical symptoms. Due to the nature of the methodology used for this test that complete sequencing coverage of the genes included in the analysis may not be available. The coverage information on the Baylor Genetics website is an estimate of the coverage expected using this methodology for each gene, but exact coverage may vary for each individual sample.

Your physician has advised you (or your child) to undergo the genetic test called the Total BluePrint Panel. This consent form will provide you with information regarding genetic testing, which you should discuss with your healthcare provider or a genetic counselor. In order to ensure that you have understood the purpose and significance of genetic testing, we have provided information about the testing process and potential results below. If you agree to have the Total BluePrint Panel test, you will be asked to sign the last page of this document, indicating that you understand the information provided and wish to have testing. You will be given a copy of this document for your records.

DESCRIPTION OF THE TOTAL BLUEPRINT PANEL TEST

The Total Blueprint Panel is a test comprised of about 4,800 genes known to be associated with diseases. This test focuses on the regions of the genes that contain important sequences of DNA that serve as the blueprint for essential proteins important for proper body function. These regions of DNA are referred to as exons. It is known that most of the errors that occur in DNA sequences that then lead to genetic disorders are located in the exons. In contrast to other sequencing tests that analyze a panel of genes ranging from one gene to hundreds of genes but could still miss the culprit gene, the Total Blueprint Panel will analyze all the exonic regions of the 4,800 or so known disease genes at one time in order to pinpoint to the changes in an individual's DNA that are contributing to their medical concerns. However, it is possible that even if this test identifies the underlying genetic cause for the disorder in your family, this information may not help in predicting prognosis or change medical management or treatment of disease.

TESTING REPORTING

When your DNA sequence is compared to a normal reference sequence, many variations or differences are expected to be found. Based on currently available information in the medical literature and in scientific databases, we will decide whether any of these variations are predicted to be causative or related to your medical condition. The report will contain results that may explain the cause of your current medical problems. It may also contain information on genes and diseases that have clear and immediate medical significance to your health or the health of family members, whether or not they relate to your current symptoms.

In addition, it may also contain information in the following categories:

Category I: Medically Actionable. The report may also contain information on genes and diseases that are considered medically actionable because they have clear and immediate medical significance to your health or the health of family members, whether or not they relate to your current symptoms. The American College of Medical Genetics (ACMG) has published guidelines for the reporting of these types of medically actionable or incidental findings (PMID: 23788249, 27854360). These guidelines include a list of genes, which may be updated periodically, that have been determined to be considered medically actionable and therefore laboratories should seek and report pathogenic variants in these genes. In accordance with an update to this policy statement (PMID: 25356965), there is the option to opt-out of receiving pathogenic variants if identified in the genes listed in ACMG policy statement.

Category II: Carrier Status. Carrier status for autosomal recessive conditions will include disorders recommended for reproductive screening by professional societies such as ACMG or ACOG, which includes: Cystic fibrosis (CFTR), Sickle cell anemia (S allele, HBB), Familial dysautonomia (IKBKAP), Tay-Sachs disease (HEXA), Canavan disease (ASPA), Fanconi anemia group C (FANCC), Niemann-Pick type A, B (SMPD1), Bloom syndrome (BLM), Mucolipidosis IV (MCOLN1), and Gaucher disease Type I (GBA).

See the following pages for options regarding receipt of certain categories of results in the report.

REPORT EXCLUSIONS

The report will not include findings in genes causing adult onset dementia syndromes for which there is presently no prevention or cure. If the proband has a phenotype that clearly indicates such a disorder we recommend pursuing targeted testing based on phenotype and not Total BluePrint Panel testing. However, please note that if the patient has a clinical presentation that could indicate such a disorder or a mixed neurological phenotype then results may be returned for genes that have an allelic association with dementia or dementia is a component of the phenotype will then be reported in the proband and the parents.

PATIENT CONFIDENTIALITY AND SPECIMEN RETENTION

- Results will only be released to a licensed healthcare provider, to those allowed access to test results by law, and to those authorized in writing.
- In rare cases, persons with genetic diagnoses have experienced problems with insurance coverage and employment. The U.S. Federal Government has enacted several laws that prohibit discrimination based on genetic test results by health insurance companies and employers. In addition, these laws prohibit unauthorized disclosure of this information. For more information, you can visit www.genome.gov/10002077.
- Samples will be retained in the laboratory in accordance with the laboratory retention policy.
- After testing is complete, the de-identified submitted specimen may be used for test development and improvement, internal validation, quality assurance, and training purposes. DNA specimens are not returned to individuals or to referring heath care providers unless specific prior arrangements have been made.
- Samples from residents of New York State will not be included in the de-identified research studies described in this authorization and will not be retained for more than 60 days after test completion, unless specifically authorized by your selection. No tests other than those authorized shall be performed on the biological sample.
- Information including results, indications for testing and clinical status obtained from the Total BluePrint Panel test may be shared with health care providers, scientists and health care databases or used in scientific publications or presentations, but the personal identifying information of all persons studied will not be revealed in such data sharing or publications/presentations.

Consent continued on next page

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			/ /	

INFORMATION AND CONSENT FOR TESTING

REQUEST FOR BIOLOGICAL PARENTAL SAMPLES

Biological parental samples are requested to aide interpretation of their child's results. Testing of parental samples will be at no additional charge (as outlined below) if received within 2 weeks after receiving the child/proband's sample. Parental testing may be at an additional charge if received at a later time. The parental samples will be tested by targeted methods for changes in genes in the below categories. A separate parental report will not be issued.

- Pathogenic or likely pathogenic variants related to patient phenotype will have Sanger confirmation.
- Variants of unclear clinical significance (VUS) with established autosomal dominant inheritance pattern.
- VUS with established autosomal recessive inheritance when there are two variant alleles.
- VUS related established X-linked inheritance if appropriate parental sample has been received.
- As determined by the laboratory, additional confirmation beyond these categories may also be performed.
- We will not report parental data for medically actionable pathological variants identified in the proband (child). If such testing is desired it can likely be completed at a later date, for no additional charge, once consent is given to your provider. Once a test order is received it will take several weeks to complete the additional testing.
- We will report parental data for carrier status recommended for reproductive screening.

I understand that:

(1) It is possible that you could have a variant in a gene included in the Total BluePrint Panel test, but the Total BluePrint Panel test was unable to detect the variant. Therefore, it is possible that you may be affected with one of the conditions tested by Total BluePrint Panel, but that the test did not detect the condition.

(2) There are several categories of test results that may be reported including:

- A clinically significant abnormality IS detected, known to be associated with a genetic disease.
- A clinically significant abnormality IS NOT detected, however my clinical diagnosis may still be correct. This event may be due to medical science's current lack of knowledge of all the gene(s) involved with the disease or the inability of the current technology to identify certain types of variants in the gene(s) which cause the disease.
- A result of uncertain clinical significance is detected. Additional testing of the patient and/or other family members may be recommended to help determine the significance of the result.

(3) Results may be unclear or indicate the need for further testing on other family members, usually parents. An error in the test interpretation may occur if the true biological relationships of the family members being tested are not as I have stated. It is possible, that additional information may come to light during these studies regarding family relationships. For example, data may suggest that family relationships are not as reported, such as non-paternity (the father of the individual is not the biological father).

(4) Genetic tests are relatively new and are being improved and expanded continuously. The tests are not considered research, but are considered to be an appropriate means of evaluation at the time of testing. This testing is complex and utilizes specialized materials so that there is always a very small possibility that the test will not work properly or that an error will occur.

(5) The laboratory does not return the remaining sample to individuals or physicians; however, in some cases, it may be possible to perform additional studies on the remaining sample. The request for additional studies must be made by my referring physician or other authorized healthcare professional and there will be an additional charge. Samples will be retained in the laboratory in accordance with the laboratory retention policy. I do understand that I have the right to withdraw this consent at any time, and the entity storing the sample shall promptly destroy the sample or portions thereof that have not already been used.

(6) Because of the complexity of genetic testing and the implications of the test results, results will only be reported to me through the ordering healthcare professional. The results are confidential and will only be released to other medical professionals or other parties with my written consent. All laboratory raw data are confidential and will not be released unless a valid court order is received.

(7) Results may have clinical or reproductive implications for my family members. In rare cases, persons with genetic diagnoses have experienced problems with insurance coverage, employment and other entities. Participation in genetic testing is completely voluntary. I understand that I may wish to obtain professional genetic counseling prior to signing this consent form.

(8) I understand that a positive test result is an indication that I or the individual(s) being tested may be predisposed to or have the specific disease or condition tested for and may wish to consider further independent testing, consult my or his/her/their physician or pursue genetic counseling.

(9) The cumulative results of Total BluePrint Panel testing on many samples may be published in the medical literature. These publications will not include any information that will identify you personally.

(10) My signature below acknowledges my voluntary participation in this test, but in no way releases the laboratory and staff from their professional and ethical responsibility to me.

(11) I will receive a copy of this consent form.

Consent continued on next page

BAYLOR GENETICS

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
GRAND BLVD. RECEIVING DOCK
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

TOTAL BLUEPRINT PANEL REQUISITION

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

INFORMATION AND CONSENT FOR TESTING

Please read the below statements carefully and check the appropriate box and initial.

For Options 1 & 2: If neither box is checked, or if form is not signed, the lab will default to the NO/ do not report option.

INITIAL

1. MEDICALLY ACTIONABLE

Pathogenic variants in genes included in the ACMG policy statement regarding recommendations for reporting of incidental findings will be reported as medically actionable on the Total BluePrint report.

_____ ◯ **YES** Please report pathogenic variants in genes determined to be medically actionable by the ACMG policy statement.

_____ ◯ **NO** Please do NOT report pathogenic variants in genes included in the ACMG policy statement.

2. CARRIER STATUS FOR AUTOSOMAL RECESSIVE CONDITIONS RECOMMENDED FOR REPRODUCTIVE CARRIER SCREENING

_____ ◯ **YES** Please report carrier status. By checking this box, I choose to receive information regarding carrier status.

_____ ◯ **NO** Please do NOT report carrier status. By checking this box, I choose to NOT receive information regarding carrier status.

For option 3: if neither box is checked, or the form is not signed, the lab will default to the YES/ release updated report option.

INITIAL

3. OPTION TO ALLOW RELEASE OF UPDATED RESULTS

We may periodically review old cases when new information is learned regarding the significance of changes in a particular gene. If a possible diagnosis can be made with this information we would like to issue an updated report to the physician who ordered your Total BluePrint Panel test. The current schedule for this review is every year, but is subject to change and does NOT include a complete review of all of your data.

_____ ◯ **YES** If new information is known regarding clinical significance of information that may not have previously been included in my Total BluePrint Panel report I would like for you to issue an updated report to my physician who ordered this Total BluePrint Panel testing.

_____ ◯ **NO** Please do NOT issue an updated report if there is new information regarding the clinical significance of my Total BluePrint Panel data that may not have been previously reported.

FOR SAMPLES SUBMITTED FROM NEW YORK STATE

INITIAL

_____ I understand that no genetic test other than those I have authorized shall be performed on my biological sample, and the sample will be destroyed at the end of testing or not more than 60 days after the sample was taken. However, by initialing here, I hereby authorize the lab to retain my sample(s) for longer retention in accordance with the laboratory retention policy for internal laboratory quality assurance studies and possible research testing.

RAW DATA CONSENT

☐ By checking this box, I agree to allow Baylor Genetics to provide the raw data such as FASTQ or VCF sequencing files from my genetic test, only upon request, to me, my physician, or the requesting laboratory.

RESEARCH & RECONTACT CONSENT

For more information on research at Baylor Genetics, please visit baylorgenetics.com. Please read the below statements carefully and check the appropriate box.

Note: If left blank, consent is interpreted as "NO."

☐ I agree to use of my de-identified specimen for research to improve genetic testing for all patients and contribute to scientific research.

☐ In addition to agreeing above, I agree to be contacted by Baylor Genetics regarding research opportunities.

SEE NEXT PAGE FOR CONSENT AUTHORIZATION

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TOTAL BLUEPRINT PANEL REQUISITION

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

INFORMATION AND CONSENT FOR TESTING

Due to the complex nature of the Total BluePrint Panel it is recommended that families seek genetic counseling in conjunction with testing.

I hereby authorize Baylor Genetics to conduct genetic testing for myself (or my child) for the Total BluePrint test as recommended by my physician.

Printed Name | Signature | Date (MM / DD / YYYY)

Relationship to Proband | Proband Name | Proband DOB (MM/DD/YYYY)

Physician's/Counselor's Signature | Date (MM / DD / YYYY)

Parental/Other Relative Testing Authorization

I hereby authorize Baylor Genetics to conduct genetic testing for myself for the purposes of clarifying results for the Total BluePrint Panel that is being performed on my child's blood sample as recommended by my child's physician. I understand that my sample will be subjected to Sanger sequencing and a separate report of these data will not be issued.

Mother's Signature | Date (MM / DD / YYYY)

Mother's Printed Name | Mother's DOB (MM/DD/YYYY)

Father's Signature | Date (MM / DD / YYYY)

Father's Printed Name | Father's DOB (MM/DD/YYYY)

Other Relative's Signature
(Or Parent/Legal Guardian) for Sample Submitted | Date (MM / DD / YYYY)

Printed Name | Other Relative's DOB (MM/DD/YYYY)

Relationship to Proband