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

Genetic 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.

6997 | MATERNAL INFORMATION

☐ Asymptomatic ☐ Symptomatic (Attach summary of findings)

Maternal Last Name

Maternal First Name | MI

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

Sample Type: ◯ Buccal Swab

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

☐ Not Available ☐ To Be Sent Later *

6997 | PATERNAL INFORMATION

☐ Asymptomatic ☐ Symptomatic (Attach summary of findings)

Paternal Last Name

Paternal First Name | MI

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

Sample Type: ◯ Buccal Swab

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

☐ Not Available ☐ To Be Sent Later *

* If parent samples are to be sent later, please include copy of this requisition form with those samples. Please send parent 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 (Buccal Swab)
- ☐ Paternal Sample (Buccal Swab)

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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			/ /	

TEST INFORMATION

This consent form will provide you with information regarding genetic testing, which you should discuss with your healthcare provider or a genetic counselor. To assist you in understanding the reason for this testing, we have provided information about the testing process and potential results below.

The purpose of genetic testing is to determine if a genetic disease may be present or if there is an increased risk for a genetic disease to occur in a patient or their family. DNA is the genetic material that we receive from our parents. Genes are made of DNA and are the instructions for maintaining the health of our body. Each person has a unique set of DNA and most of the differences in our DNA do not impact our health. Genetic testing analyzes DNA to find any abnormal changes (mutations also called variants) that might cause disease, make it more likely to develop disease, and/or increase the chance of having a child affected by disease.

The testing ordered by your healthcare provider can determine if you or your child have a variant associated with a genetic disease. "Your child" can also mean your unborn child, for the purposes of this consent.

Depending on why genetic testing is needed, you might be tested for:

- A known variant that has already been found in your family
- A single gene or variant that causes a specific, suspected disease.
- Multiple genes at the same time. These genes might cause similar diseases or might cause diseases that are unrelated to each other.
- Multiple types of testing that each test for different variants.

RESULTS

There are several types of test results that may be reported including:

- Positive: Positive or "abnormal" results mean there is a change in the DNA found that is related to your/your child's medical issues or that you/your child are at an increased risk of developing a disease in the future. It is possible to test positive for more than one variant. Positive results might include pathogenic variants (variants known to be associated with disease) and likely pathogenic variants (variants that are likely to be associated with disease).
- Negative: Negative or "normal" results mean no relevant variants related to your/your child's medical issues were detected or that you/your child are not expected to be at an increased risk for developing a disease in the future. This might indicate that there are no variants associated with disease in the gene(s) tested. Genetic testing, while highly accurate, might not detect a variant present in the gene(s) tested. This can be due to limitations of the information available about the gene(s) being tested, or limitations of the testing technology.
- Variant of Uncertain Significance: Testing can detect variant(s) in DNA which we do not yet fully understand. These are also referred to as variants of uncertain significance (VUS). Additional testing may be recommended for you or your family if a VUS is identified in a gene that may be associated with your/your child's medical condition.
- Secondary / Incidental Findings: Testing can sometimes detect a variant in a person's DNA unrelated to the reason for testing. If this variant is expected to have medical or reproductive significance, it is called a secondary or incidental finding.

CONSIDERATIONS AND LIMITATIONS

- This consent form cannot be used for whole exome sequencing (WES), whole genome sequencing (WGS), or Huntington's disease testing. These tests have specific consents that are located at https://www.baylorgenetics.com/consent/.
- Results may indicate you have a genetic disease, are at increased risk to develop a genetic disease, and/or be at an increased risk to have a child with a genetic disease. It is important to understand that genetic tests, even if negative, cannot rule out every variant. It is not possible to exclude risks for all genetic diseases for you and your family members.
- Depending on the type of genetic testing performed and the results, additional genetic testing or other testing may be needed to fully understand the likelihood of your developing the disease or the severity of the disease. This additional testing might be needed for you/your child or other members of your family.
- It is recommended that you discuss genetic testing with your healthcare provider or genetic counselor before signing this consent and again after results are made available.
- It may not always be possible to complete testing. as sometimes the sample does not have enough DNA to perform testing or other reasons. In these cases, another sample may need to be sent to the laboratory to perform testing.

PATIENT CONFIDENTIALITY AND SPECIMEN RETENTION

- If several family members are tested, the correct interpretation of the results depends on the information provided about the relationships amongst family members. In rare cases, genetic testing can reveal that the true biological relationships in a family are not as they were reported. If a difference is identified, it may be necessary to share this information with the healthcare provider who ordered the testing.

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			/ /	

PATIENT CONFIDENTIALITY AND SPECIMEN RETENTION (CONT.)

- Genetic testing is highly accurate, however in rare cases, inaccurate results may occur. Reasons for this include, but are not limited to, mislabeled samples, inaccurate reporting of clinical/medical information, or rare technical errors.
- If you sign this consent form, but you no longer wish to have your sample(s) tested, you can contact the healthcare provider who ordered the test to cancel the test. If you wish to cancel testing, the laboratory must be notified of the cancellation request before 5 PM CST the business day after the sample has begun testing. If the laboratory is not notified of your cancellation request until after this time, you will be charged for the full cost of the test.
- Only Baylor Genetics and Baylor Genetics contracted partners will have access to the sample(s) provided to conduct the requested testing. Results will only be released to the following person(s): (i) a licensed healthcare provider, (ii) those authorized in writing, (iii) the patient or their personal representative, and (iv) those allowed access to test results by law. I understand that I have the right to access any test results directly from Baylor Genetics by providing a written request. I also understand that laboratory raw data, while not routinely released as part of the testing process, can be requested by providing a written request or HIPAA Authorization Form.
- 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 research studies without your written consent and will not be retained for more than 60 days after receipt of the sample. No tests other than those authorized shall be performed on the biological sample.
- By signing this consent form, I understand and agree that variants identified may also be submitted to public databases, such as ClinVar. Such submission serves to contribute knowledge to the medical community. I understand that limited clinical information is also required for the submission of information to ClinVar's database and further that the contents of this limited clinical information may, although unlikely, include information that may identify me personally.
- It is possible that even if the test identifies the underlying genetic cause for the disease in your family, this information may not help in predicting the progression of disease or change management or treatment of disease.

FINANCIAL AGREEMENT AND GUARANTEE

By signing this consent form, I accept full and complete financial responsibility for all genetic testing ordered by my healthcare provider. For insurance billing, I hereby authorize Baylor Genetics to bill my health insurance plan on my behalf, and further authorize Baylor Genetics to release any information to my insurance carrier which is reasonably required for billing. I additionally designate Baylor Genetics as my designated representative for purposes of appealing any denial of benefits by my insurance carrier. I irrevocably assign associated payment to Baylor Genetics, and direct that payment be made directly to Baylor Genetics. I understand that my out-of-pocket costs may be different than the estimated amount indicated to me by Baylor Genetics as part of a verification of benefits investigation. I agree to be financially responsible for all amounts as indicated on the explanation of benefits issued by my health insurance plan. If my insurance provider sends a payment directly to me for unpaid services performed by Baylor Genetics on my behalf, I agree to endorse the insurance check as appropriate and forward such check to Baylor Genetics within thirty (30) days of receipt thereof, as payment towards Baylor Genetics' claim for services rendered. If I do not have health insurance, I agree to pay for the full cost of the genetic testing that was ordered by my healthcare provider and billed to me by Baylor Genetics.

I understand that a completed Advance Beneficiary Notice (ABN) is required for Medicare patients if the service is deemed not medically necessary.

RECONTACT FOR RESEARCH CONSENT

Baylor Genetics participates in research relating to health, disease prevention, drug development, and other scientific purposes. Baylor Genetics may contact patients or their provider(s) directly as part of this research. I agree to allow Baylor Genetics to contact me or my provider(s) about possible research involving the sample(s) and/or information associated with this testing. I understand that patients generally receive no compensation for this participation in research. For more information on research at Baylor Genetics, please visit baylorgenetics.com.

If I wish to opt out of being recontacted for research purposes by Baylor Genetics, I understand that I may check the box below:

☐ Please do not contact me regarding any research that uses information obtained from this testing.

For any research I may be contacted about, I prefer contact through the following methods (please check all that apply – if no choices are selected, contact will be made via secure email if possible):

☐ Email ☐ Phone ☐ Mail

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TOTAL BLUEPRINT PANEL REQUISITION

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

PATIENT AUTHORIZATION

By signing this statement of consent, I acknowledge that I have read, understand, and hereby grant my informed consent for genetic testing. I have received appropriate explanations from my healthcare provider about the planned genetic test(s) and possible results. I have been informed by my healthcare provider about the availability and importance of genetic counseling and have been provided with written information identifying a genetic counselor or medical geneticist who can provide such counseling services. All my questions have been answered and I have had the necessary time to make an informed decision about the genetic test(s).

I hereby give permission to Baylor Genetics to conduct genetic testing as recommended by my physician.

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

Patient's Parent / Personal Representative* Name	Patient's Parent / Personal Representative Signature	Date (MM / DD / YYYY)
		____ / ____ / ____

Relationship of Personal Representative to the Patient	Ordering Provider's Signature	Date (MM / DD / YYYY)
		____ / ____ / ____

*If you are signing as a person with legal authority to act on behalf of the patient, you may be required to provide evidence of your authority.