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

TUMOR ANALYSIS 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 Code

Phone | Accession # | Hospital / Medical Record # | Patient discharged from the hospital/facility: ◯ Yes ◯ No

Biological Sex: ◯ Female ◯ Male ◯ Unknown | Gender identity (if different from left):

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

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 / Guardian Printed Name | Patient / Guardian 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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TUMOR ANALYSIS REQUISITION

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

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): _____

SAMPLE INFORMATION

Date of Collection (MM / DD / YYYY) | Time of Collection

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.

REQUIRED FOR BREAST CANCER FFPE SAMPLES

Method of Fixation | Time to Tissue Fixation | Tissue Fixation Time

SAMPLE TYPE (PLEASE REFER TO PAGE 5 FOR SAMPLE REQUIREMENTS)

- ◯ Blood in EDTA Tube (Purple-Top) +
- ◯ Blood in Sodium Heparin (Green-Top) +
- ◯ Bone Marrow in Sodium Heparin (Green-Top) +
- ◯ Bone Marrow in EDTA (Purple-Top) +
- ◯ FFPE - Slides * #: _____
- ◯ FFPE - Tissue Block *
- ◯ Fresh Frozen Tissue ± *
- ◯ Tissue in Medium ± *
- ◯ DNA (Concentration) + ± *: _____
- ◯ RNA (Concentration) + ± *: _____
- ◯ Other **: _____

\+ For hematologic samples, attach clinical notes and concurrent laboratory reports (such as CBC, flow cytometry, cytogenetics, FISH, molecular testing, and pathology reports). Concurrent laboratory reports may be sent later as soon as available.

* Surgical Pathology report MUST be attached for all tissue samples but may be sent later as soon as it becomes available.

** Please call for consultation before ordering test.

± Please send a corresponding representative H+E slide, if available.

Biological Sex of Bone Marrow Transplant Donor (select one): ◯ Female ◯ Male

INDICATION FOR TESTING (REQUIRED)

Indication(s) | ICD10 Diagnosis Code(s)

RETURN OF FFPE SPECIMENS

☐ Check if block and/or H&E stained slide should be returned. Fill out the return address information below, or affix preprinted label.

This section will be used as the return address label.

Institution | ATTN

Address

City | State | ZIP

SPECIMEN RETRIEVAL

☐ I want Baylor Genetics to request the specimen. (Complete information below)

Location of Specimen

Contact Name

Phone # | Fax #

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TUMOR ANALYSIS REQUISITION

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

BH = Blood in Sodium Heparin (green-top)
TM = Tissue in Medium
BMH = Bone Marrow in Sodium Heparin (green-top)
FFPE = Slides/Block
BE = Blood in EDTA (purple-top)
FFPE = Slides/Block
BME = Bone Marrow in EDTA (purple-top)
T = Fresh Frozen Tissue

CANCER MOLECULAR ANALYSIS

SINGLE GENE TESTING

	TEST CODE	TEST NAME	SAMPLE TYPE
☐	9202	B-Cell Clonality Screening (IgH and IgK) by PCR	BE, BME, FFPE, T
☐	9065	BCR-ABL1, Major (p210), Quantitative	BE, BME
☐	8972	BCR-ABL1, Minor (p190), Quantitative	BE, BME
☐	9070	BCR-ABL1, Qualitative Analysis w/ Reflex to BCR-ABL1 Quantitative [4]	BE, BME
☐	9305	BCR-ABL1 Mutation Analysis for Tyrosine Kinase Inhibitor Resistance by NGS	BE, BME
☐	9003	BRAF V600 Mutation Analysis	BE, BME, FFPE
☐	9016	CALR (Calreticulin) Exon 9 Mutation Analysis by PCR	BE, BME
☐	9086	CEBPA Mutation Detection	BE, BME
☐	9030	EGFR Mutation Detection by Pyrosequencing	FFPE
☐	9045	FLT3 Mutation Detection by PCR [2]	BE, BME
☐	9104	Gastrointestinal Stromal Tumor Mutation (KIT, PDGFRA)	FFPE
☐	9060	IGHV Mutation Analysis by Sequencing	BE, BME
☐	9015	JAK2 Exon 12 Mutation Analysis by PCR	BE, BME
☐	9010	JAK2 Gene, V617F Mutation, Qualitative	BE, BME
☐	8970	KIT (D816V) Mutation by PCR	BE, BME
☐	9103	KIT Mutations, Melanoma (including PDGFRA)	FFPE
☐	9105	KIT Mutations in AML by Fragment Analysis and Sequencing	BE, BME
☐	9128	KRAS Mutation Detection	FFPE
☐	8974	MGMT Methylation Detection by PCR	FFPE
☐	9150	Microsatellite Instability (MSI), HNPCC/Lynch Syndrome, by PCR [3]	FFPE
☐	9020	MPL Codon 515 Mutation Detection by Pyrosequencing, Quantitative	BE, BME
☐	8973	MYD88 L265P Mutation Detection by PCR, Quantitative	BE, BME, FFPE
☐	9005	NPM1 Mutation Detection by RT-PCR, Quantitative	BE, BME
☐	8971	NRAS Mutation Detection by Pyrosequencing	FFPE
☐	8976	PD-L1 28-8 pharmDx by Immunohistochemistry with Interpretation, nivolumab (OPDIVO)	FFPE
☐	8975	PD-L1 22C3 IHC for NSCLC by Immunohistochemistry with Interpretation, pembrolizumab (KEYTRUDA)	FFPE
☐	8977	PD-L1 22C3 IHC with Combined Positive Score (CPS) Interpretation, pembrolizumab (KEYTRUDA)	FFPE
☐	9080	PML-RARA Translocation, t(15;17) by RT-PCR, Quantitative	BE, BME
☐	9217	T-Cell Clonality Screening by PCR	BE, BME, FFPE, T
☐	9055	TP53 Somatic Mutation, Prognostic	BE, BME, FFPE

REFLEX TESTS

Reflex Request (Please describe below):

[1] For test code 9505: If sending FFPE slides, 20 slides are required for submission.
[2] For test code 9045: Test will be sent to LabPMM for analysis and reporting.
[3] For test code 9150: Please submit BOTH a source of tumor tissue (FFPE block/slides) AND a source of normal tissue (FFPE block/slides).
[4] For test code 9070: If BCR-ABL1, Major (p210) is detected, reflex to 9065, and if BCR-ABL1, Minor (p190) is detected, reflex to 8972.

CYTOGENETIC TESTS

SINGLE FISH PROBES

	TEST CODE	TEST NAME	SAMPLE TYPE
☐	8030	ALK Rearrangement	FFPE
☐	8725	AML1/ETO: t(8;21) [AML]	BH, BMH
☐	8785	BCL2 Rearrangement	FFPE
☐	8775	BCL6 Rearrangement	BH, BMH, FFPE
☐	8750	BCR/ABL: t(9;22) [CML/ALL/AML]	BH, BMH
☐	8740	CBFB: inv(16) [AML]	BH, BMH
☐	8730	CHIC2: Deleted 4q [Hypereosinophilic Syndrome]	BH, BMH
☐	8710	Deletion 5: [MDS]	BH, BMH
☐	8715	Deletion 7: [MDS]	BH, BMH
☐	8720	Deletion 20q12: [MDS]	BH, BMH
☐	8065	DXZ1/DYZ3	BH, BMH
☐	8035	EGFR	FFPE
☐	8385	Gain Chromosome 8	BH, BMH
☐	8780	IGH Rearrangement	BH, BMH
☐	8770	IGH/CCND1: t(11;14) [Mantle Cell Lymphoma]	BH, BMH, FFPE
☐	8786	MALT1 Lymphoma	BH, BMH
☐	8095	MET Amplification	FFPE
☐	8745	MLL: 11q23	BH, BMH
☐	8760	MYC translocation	BH, BMH, FFPE
☐	8788	p53	BH, BMH
☐	8735	PML/RARA: t(15;17) [AML]	BH, BMH
☐	8031	RET Rearrangement	FFPE
☐	8781	ROS1 Rearrangement	FFPE
☐	8075	SS18 [Synovial Sarcoma]	FFPE
☐	8080	TCF3/PBX1 [ALL]	BH, BMH
☐	8755	TEL/AML1: t(12;21) [ALL]	BH, BMH
☐	8400	OTHER, Probe Name:	

CLASSICAL CHROMOSOME ANALYSIS

	TEST CODE	TEST NAME	SAMPLE TYPE
☐	8300	Hematologic Cancer	BH, BMH
☐	8050	Solid Tumor	TM

FISH PANELS

	TEST CODE	TEST NAME	SAMPLE TYPE
☐	8789	Aggressive/High-Grade B-Cell Lymphoma (MYC translocation, BCL2 rearrangement, BCL6 rearrangement)	FFPE
☐	8010	ALL Adult (CDKN2A del, BCR/ABL gene fusion, KMT2A rearrangement, IGH rearrangement, Trisomy 4, Trisomy 10)	BH, BMH
☐	8012	ALL Ph-Like FISH Panel (PDGFRb, BCR/ABL1-ASS1, JAK2, EPOR, CRLF2)	BH, BMH
☐	8792	ALL Pediatric (BCR/ABL translocation, KMT2A rearrangement, ETV6/RUNX1 translocation, Trisomy 4, Trisomy 10, TCF3/PBX1 amplification/deletion)	BM, BMH
☐	8000	AML (Trisomy 8, AML/ETO, MLL rearrangement, PML/RARA, CBFB inversion)	BH, BMH
☐	8040	CLL (Trisomy 12, ATM del, p53 del, MYB del, 13q del, IGH rearrangement, IGH/CCND1 fusion)	BH, BMH
☐	8791	Eosinophilia (PDGFRB rearrangement, FGFR1 rearrangement, JAK2 rearrangement, PDGFRA/CHIC2/FIP1L1 rearrangement, CBFB rearrangement)	BH, BMH
☐	8005	MDS (5 del, 7 del, Trisomy 8, MLL rearrangement, 20q del)	BH, BMH
☐	8015	Multiple Myeloma (Trisomy 9, RB1 del, IGH rearrangement, Trisomy 15, p53 del, Trisomy 7, CKS1B/CDKN2C amplification/deletion) ☐ If IGH rearrangement positive, reflex to 8790	BH, BMH
☐	8790	Multiple Myeloma IgH Rearrangement (IGH/MAF fusion, IGH/FGFR3 fusion, IGH/CCND1 fusion)	BH, BMH
☐	8020	NHL (BCL6 rearrangement, IGH/CCND1 fusion, MYC rearrangement, MALT1 rearrangement, BCL2 rearrangement)	BH, BMH
☐	8787	Non-Small Cell Lung Carcinoma (ALK rearrangement, MET amplification, RET rearrangement, ROS1 rearrangement)	FFPE
☐	8793	NTRK (NTRK1 rearrangement, NTRK2 rearrangement, NTRK3 rearrangement)	FFPE

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TUMOR ANALYSIS REQUISITION

SAMPLE SPECIFICATIONS TABLE

FOR CLIENT INFORMATION ONLY. Not required with sample submission.

ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT		SHIPPING INSTRUCTIONS	SPECIAL NOTES
		(2 YRS - ADULT)	(NEWBORN - 2YRS)		
BE	Blood in EDTA tube (purple-top)	3 - 5 cc	2 -3 cc	Ship at room or refrigerated temperature in an insulated container by overnight courier. Do not heat or freeze. Specimen should arrive in the laboratory within 24-48 hours of collection.	Attach clinical notes and concurrent laboratory reports (such as CBC, flow cytometry, cytogenetics, FISH, molecular testing, and pathology reports). Concurrent laboratory results may be sent later as soon as available.
BH	Blood in Sodium Heparin tube (green-top)	3 - 5 cc	2 -3 cc	Ship at room or refrigerated temperature in an insulated container by overnight courier. Do not heat or freeze. Specimen should arrive in the laboratory within 24-48 hours of collection.	Attach clinical notes and concurrent laboratory reports (such as CBC, flow cytometry, cytogenetics, FISH, molecular testing, and pathology reports). Concurrent laboratory results may be sent later as soon as available.
BME	Bone Marrow in EDTA tube (purple-top)	3 - 5 cc	2 -3 cc	Ship at room or refrigerated temperature in an insulated container by overnight courier. Do not heat or freeze. Specimen should arrive in the laboratory within 24-48 hours of collection.	Attach clinical notes and concurrent laboratory reports (such as CBC, flow cytometry, cytogenetics, FISH, molecular testing, and pathology reports). Concurrent laboratory results may be sent later as soon as available.
BMH	Bone Marrow in Sodium Heparin tube (green-top)	3 - 5 cc	2 -3 cc	Ship at room or refrigerated temperature in an insulated container by overnight courier. Do not heat or freeze. Specimen should arrive in the laboratory within 24-48 hours of collection.	Attach clinical notes and concurrent laboratory reports (such as CBC, flow cytometry, cytogenetics, FISH, molecular testing, and pathology reports). Concurrent laboratory results may be sent later as soon as available.
DNA	DNA, Extracted	At Least 100 ng	At Least 100 ng	Ship at room or refrigerated temperature in an insulated container by overnight courier. May also be shipped frozen on minimum of 10 lbs of dry ice in an insulated container by overnight courier.	Minimum concentration of 25ng/uL. Attach clinical notes, concurrent laboratory reports, and/or surgical pathology report, as applicable. Please send a corresponding representative H+E slide, if available.
FFPE	FFPE - Block	See Special Notes	See Special Notes	Ship at room temperature in an insulated container by overnight courier. If shipping during the summer months please include a cold-pack to avoid extreme temperatures. Do not heat or freeze.	Paraffin-embedded, formalin-fixed tissue block containing ≥20% tumor nuclei with a minimum tumor surface area of 5mm x 5mm ($25mm^2$). Decalcified specimens are not accepted. Surgical pathology report must be attached for all tissue samples.
FFPE	FFPE - Slides	See Special Notes	See Special Notes	Ship at room temperature in an insulated container by overnight courier. If shipping during the summer months please include a cold-pack to avoid extreme temperatures. Do not heat or freeze.	10 - 15 unstained 5µm FFPE slides containing ≥20% tumor nuclei with a minimum tumor surface area of 5mm x 5mm ($25mm^2$). For smaller specimens, 20 or more unstained 5µm FFPE slides containing ≥20% tumor nuclei should be submitted. Decalcified specimens are not accepted. Surgical pathology report must be attached for all tissue samples. For test codes 9505: 20 slides are required for submission.
RNA	RNA, Extracted	At Least 100 ng	At Least 100 ng	Ship frozen on minimum of 10 lbs of dry ice in an insulated container by overnight courier.	Minimum concentration of 25ng/uL. Attach clinical notes, concurrent laboratory reports, and/or surgical pathology report, as applicable. Please send a corresponding representative H+E slide, if available.
SA	Saliva	See Special Notes	See Special Notes	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	Collected with Oragene DNA Self-Collection Kit (provided by Baylor Genetics with instructions).
T	Fresh Frozen Tissue	150 mg	150 mg	Ship frozen on minimum of 10 lbs of dry ice in an insulated container by overnight courier.	Fresh tissue snap frozen at ≤-20°C. Store at ≤-20°C. Surgical pathology report must be attached for all tissue samples. Surgical pathology report may be sent later as soon as it becomes available. Please send a corresponding representative H+E slide, if available.
TM	Fresh Tissue in Medium	0.5 - 1 cm^3 or more	0.5 - 1 cm^3 or more	Ship at room or refrigerated temperature in an insulated container by overnight courier. Do not heat or freeze. Specimen should arrive in the laboratory within 48 hours of collection.	Transport tumor tissue in a sterile, screw-top container filled with tissue culture transport medium. If tissue culture transport medium is not available, collect in plain RPMI, Hanks solution, or saline. Surgical pathology report must be attached for all tissue samples. Surgical pathology report may be sent later as soon as it becomes available. Please send a corresponding representative H+E slide, if available.

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INFORMED CONSENT FOR TUMOR ANALYSIS TESTING

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

INFORMED CONSENT FOR GENETIC TESTING

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. 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.

The purpose of genetic testing is to identify the cause of a suspected disease in you or your family. The testing analyzes your genetic material (DNA) for an abnormal change (variant) that could explain the disease you or members of your family are experiencing. Genetic testing can be a diagnostic test, which is used to identify or rule out a specific genetic condition. Genetic screening tests are used to assess the chance for a person to develop or have a child with a genetic condition. Genetic screening tests are not typically diagnostic, and results may require additional testing.

The purpose of this test is to see if you or your child may have a genetic variant or chromosome rearrangement. This may cause a genetic disorder or may determine the chance that you or your child will develop or pass on a genetic disorder in the future. "Your child" can also mean your unborn child, for the purposes of this consent.

In a genetic test, depending on the case, you can be tested for:

- A single gene/variant responsible for a specific, suspected genetic disease.
- Multiple genes in parallel.

The sample/specimen that is needed to perform the genetic test is stated in the test order form and is typically blood or purified DNA, but may also be tissue, saliva or buccal swab.

RESULTS

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

- **Positive:** Positive or "abnormal" results mean there is a change in the genetic material found that is related to your/your child's medical issues or that you/your child are at an increased risk of developing the disorder in the future. It is possible to test positive for more than one genetic variant.
- **Negative:** Negative or "normal" results mean no relevant genetic change related to your/your child's medical issues was detected. This does not mean there is no genetic change, but it may mean that the type of testing performed could not detect it.
- **Results of Unclear Significance:** Testing can detect change(s) in DNA which we do not yet fully understand. These alterations are also referred to as variants of uncertain significance (VUS). Additional studies may be recommended if a VUS is identified in a gene that may be associated with your/your child's medical concerns.
- **Secondary / Incidental Findings:** Testing can sometimes detect a change in a person's DNA unrelated to the reason for testing. If this change has medical or reproductive significance, it is called a secondary or incidental finding.

CONSIDERATIONS AND LIMITATIONS

- Results may indicate affected status, increased risk to someday be affected with, and/or reproductive risk for a genetic disorder. It is important to understand that genetic tests, even if negative, are not exhaustive. It is not possible to exclude risks for all possible genetic diseases for yourself and your family members.
- A positive test result is an indication that the individual(s) being tested may be predisposed to or have the specific disease or condition which prompted testing. You might consider additional independent testing, consult a personal physician, or pursue genetic counseling.
- It is possible that the knowledge of the test results may result in psychological stress for you and your family. It is always recommended to discuss the results with your healthcare provider or genetic counselor.
- If several family members are tested, the correct interpretation of the results depends on the provided relationships between 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 discrepancy is identified, it may be necessary to report this to the physician who ordered the testing.
- Genetic testing is highly accurate. Rarely, inaccurate results may occur for various reasons. These reasons 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 your physician to cancel the test. If testing is complete, but you have not received your results yet, you can inform your physician that you no longer wish to receive the results. If you withdraw consent for testing after 5pm CST the next business day following sample receipt by the laboratory, you will be charged for the full cost of the test.

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.

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INFORMED CONSENT FOR TUMOR ANALYSIS TESTING

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

INFORMED CONSENT FOR GENETIC TESTING

PATIENT CONFIDENTIALITY AND SPECIMEN RETENTION (CONT.)

- 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 the sample was taken, 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 this testing may be shared with healthcare providers, scientists and healthcare 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.

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.

☐ I am a New York State Resident, and I give Baylor Genetics permission to store my specimen in accordance to the laboratory retention policy for internal quality assurance and possible research studies.

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

PATIENT AUTHORIZATION

By signing this statement of consent, I acknowledge that I have read and understand the informed consent for genetic testing. I have received appropriate explanations from my physician regarding the purpose, scope, type and significance of the planned genetic testing and achievable results. All my questions have been answered and I have had the necessary time to make an informed decision about the genetic test.

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

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

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