

NGS 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 #		Biological Sex: <input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> 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
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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)	Name of Insured	Insured Date of Birth (MM / DD / YYYY)		
Patient's Relationship to Insured	Phone of Insured	Patient's Relationship to Insured	Phone of Insured		
Address of Insured		Address of Insured			
City	State	Zip	City	State	Zip
Primary Insurance Co. Name	Primary Insurance Co. Phone	Secondary Insurance Co. Name	Secondary Insurance Co. Phone		
Primary Member Policy #	Primary Member Group #	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)
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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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Patient Last Name

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MI

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

Biological Sex

INSTRUCTIONS FOR ORDERING

Listed below are testing options that allow for comprehensive assessment to increase the diagnostic yield for patients with a focused disease phenotype. Any combination of panels can be ordered based on the disease expression.

DISEASE-SPECIFIC PANELS | 1300

NEUROMUSCULAR PANELS

Neuromuscular Disorders Panel

SAMPLE TYPES

Please refer to www.baylorgenetics.com for full sample requirements.

Blood in EDTA

Cultured Skin Fibroblast

Buccal Swab

Saliva

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.

ITEM CHECKLIST FOR TESTING

Proband Sample (Required)

Clinical Note/Summary

Indication for Study

Signed Consent Form

Requisition

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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 results. If the laboratory requires additional information, please indicate the health care provider to be contacted:

 Physician Name Physician Phone ICD-10 Diagnosis Code(s)

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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MI _____

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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 Polydactyly
- 0001829 Foot Polydactyly
- 0006101 Finger Syndactyly
- 0001770 Toe Syndactyly
- 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 Tracheoesophageal 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

ENDOCRINE **HEMATOLOGY** **OTHER**

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

- 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
- _____
- _____

- Organomegaly
- Chronic Infections
- 0004311 Abnormality of Macrophages
- 0001954 Episodic Fever
- 0004313 Hypogammaglobulinemia
- 0010701 Abnormal Immunoglobulins
- 0002721 Immunodeficiency
- 0012088 Abnormal urinary odor
- 0012537 Food intolerance
- 0008067 Abnormally lax or hyperextensible skin
- Abnormal Movements
- Family History of Similar Disorder
- 0001254 Lethargy
- 0002415 Leukodystrophy
- _____
- _____

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
- _____
- _____

CANCER

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

GENES OF INTEREST

ADDITIONAL CLINICAL INFORMATION

DIFFERENTIAL DIAGNOSIS

Consent on next page



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INFORMATION AND CONSENT FOR TESTING

DESCRIPTION OF DISEASE-SPECIFIC PANEL TEST

The disease-specific NGS panel test is developed to identify changes in an individual's DNA that cause or contribute to their medical concerns. Disease-specific NGS panels analyze a specific set of genes that are specific to a disease type, reducing the number of Variants of Unknown Significance (VUSs) and providing specific, low complexity reports. The NGS panels are carved out of the Whole Exome Sequencing (WES) test. The exome refers to the portion of the human genome that contains functionally important sequences of DNA that direct the body to make proteins essential for the body to work properly. These regions of DNA are called exons. It is known that most of the errors that occur in DNA sequences that then lead to genetic disorders are in the exons. NGS panels account for genes, specific to certain disease types, preventing the detection of variants that are unrelated to the disease in purview.

TESTING REPORTING

When your NGS Panel sequence is compared to a normal reference sequence, many variations or differences are expected to be found. Based on currently available medical and scientific information, we will decide whether any of these variations are predicted to be causative or related to your medical concerns. The report will contain results that may explain the cause of your current medical problems.

You may receive any of the following types of results:

- **Positive Results:** Positive or "abnormal" results mean there is a change in the genetic material related to the patient's medical issues.
 - **Negative Results:** Negative or "normal" results mean no relevant genetic change could be detected. This does not mean that there is no genetic change, but it may mean the test could not detect it.
 - **Results of Unclear Significance:** Tests can detect change(s) in DNA that do not have a clear meaning. Every person has changes in their DNA; not all of these changes cause medical issues.
1. It is possible that you could have a variant in a gene included in the Panel test, but the Panel test was unable to detect the variant. Therefore, it is possible that you may be affected with one of the conditions tested by Panel, but that the test did not detect the condition.
 2. The Panel test does not analyze 100% of the genes in the human genome. There are some genes that cannot be included in the test due to technical reasons.
 3. Results may be unclear or indicate the need for further testing on other family members.
 4. If you sign the consent form, but you no longer wish to have your samples tested, you can contact your doctor to cancel the test. If testing is complete, but you have not received your results yet, you can inform your doctor that you no longer wish to receive the results. However, if you withdraw consent for testing after 5p.m. CST, the next business day following sample receipt by the laboratory, you will be charged for the full cost of the test.
 5. Information including results, indications for testing and clinical status obtained from the 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.
 6. Variants identified may also be submitted to public databases, such as ClinVar, to contribute knowledge to the medical profession. Usually limited clinical information is also required for the submission. However, it is unlikely that contents of the database submissions will include any information that will identify you personally.
 7. It is possible that even if the test identifies the underlying genetic cause for the disorder in your family, this information may not help in predicting prognosis or change management or treatment of disease.

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 health 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 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.

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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.

CONTACT INFORMATION

Phone # Alternative Phone # Email

Address City State Zip

Preferred Method of Contact: Email Mail Phone

PATIENT SIGNATURE

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

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

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