BAYLOR GENETICS
2450 HOLCOMBE BLVD.
SUITE 2210
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

INHERITED EYE DISORDERS TESTING 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): _____

INDICATION FOR TESTING (REQUIRED)

☐ Symptomatic (Summarize below) ☐ Symptomatic with Family History

_____

☐ Asymptomatic

◯ Population Screening ◯ Positive Family History

Disease | Gene | Variant

ICD10 Diagnosis Code(s): _____

SAMPLE

SAMPLE TYPE

- ◯ Blood in EDTA-tube (purple-top)
- ◯ Blood in Heparin-tube (green-top)
- ◯ Cultured Skin Fibroblast
- ◯ Other (Specify) _____
- ◯ DNA
- ◯ Saliva
- ◯ Skin Biopsy
- ◯ Tissue

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.

Blood should not be sent from patients who have had a bone marrow transplant or recent blood transfusion

Date of Collection (MM/DD/YY)

TESTING OPTIONS

☐ Targeted Sequencing for Known Familial Mutation (If selected, specify test code and gene below and complete section to the right)

Test Code | Gene

☐ Full Gene Sequencing

☐ Deletion/ Duplication Analysis

FOR TARGETED TESTING SELECTION ONLY

Proband Last Name | Proband First Name

Date of Birth (MM/DD/YY) | Relationship of Proband to Patient

Proband testing location (Select one)

☐ Baylor Genetics Lab# Family#

☐ Another laboratory

1. Attach a copy of the Proband test results
2. A positive control sample of the Proband is requested. Please provide, if available.

INHERITED EYE DISORDERS TESTS

CYTOGENETIC TESTS

TEST CODE	TEST NAME	SAMPLE TYPE*	SPECIFY GENE OF INTEREST	SPECIFY REGION OF INTEREST
☐ 8665	Chromosomal Microarray Analysis (CMA) - HR + SNP Screen (Comprehensive)	BE, DNA, CF, SB, BUC		
☐ 8655	Chromosomal Microarray Analysis (CMA) - HR	BE, DNA, CF, SB, BUC		

MITOCHONDRIAL DNA (MTDNA) MUTATION SCREENS

TEST CODE	TEST NAME	SAMPLE TYPE*
☐ 2010	Advanced mtDNA Point Mutations and Deletions by Massively Parallel Sequencing (BCM-MitomeNGSSM)	BE, DNA, CF, T
☐ 2055	Comprehensive mtDNA Analysis by Massively Parallel Sequencing (BCM-MitomeNGSSM)	BE, DNA, CF, T

* Refer to Sample Specifications Table (page 5)

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FISH STUDIES

MASSIVELY PARALLEL SEQUENCING (BCM-MITOMENGSSM) PANELS

TEST CODE	TEST NAME	SAMPLE TYPE*	TEST CODE	TEST NAME	SAMPLE TYPE*
☐ 20100	Albinism Panel (13 genes)	BE, DNA, CF, SA, BUC	☐ 5255	Primary Open Angle Glaucoma Panel (MYOC, OPTN)	BE, DNA, CF, SA, BUC
☐ 5260	Developmental Glaucoma Panel (8 genes)	BE, DNA, CF, SA, BUC	☐ 2140	Progressive External Ophthalmoplegia Panel (10 genes)	BE, DNA, CF, SA, BUC
☐ 5250	Familial Exudative Vitreoretinopathy Panel (FZD4, LRP5, NDP, and TSPAN12)	BE, DNA, CF, SA, BUC	☐ 2190	Retinitis Pigmentosa + RPGR orf15 by NGS (66 genes)	BE, DNA, CF, SA, BUC
☐ 5090	Leber Congential Amaurosis Panel (19 genes)	BE, DNA, CF, SA, BUC	☐ 2195	Usher Syndrome Panel (9 genes)	BE, DNA, CF, SA, BUC

DNA COPY NUMBER ANALYSIS

TEST CODE	TEST NAME	SAMPLE TYPE*	SPECIFY GENE OF INTEREST				
☐ 2000	MitoMet®Plus aCGH Analysis	BE					
☐ 2001	Oligonucleotide Targeted Array Analysis (Single Target Gene)	BE					
☐ 2003	Oligonucleotide Targeted Array Analysis (Up to 5 Target Genes)	BE					

SINGLE GENE ANALYSIS

If a test is not found on this form, please obtain the test code from our website (www.BMGL.com) and write in the below space(s).

Test Code | Gene | Test Code | Gene | Test Code | Gene

Test Name | Test Name | Test Name

TEST CODE	TEST NAME	DISORDER	SAMPLE TYPE*
☐ 6603	ABCA4 Comprehensive (Seq. & Del/Dup Analysis)	ABCA4-Related Disorders	BE, DNA
☐ 2924	BEST1 Comprehensive (Seq. & Del/Dup Analysis)	BEST1-Related Disorders	BE, DNA
☐ 2419	CEP290 Comprehensive (Seq. & Del/Dup Analysis) CEP290	CEP290-Related Disorders	BE, DNA
☐ 6655	CDH23 Sequence Analysis	CDH23-Related Disorders	BE, DNA
☐ 6660	CLRN1 Sequence Analysis	CLRN1-Related Disorders	BE, DNA
☐ 7521	COL2A1 Comprehensive (Seq. & Del/Dup Analysis)	COL2A1-Related Disorders	BE, DNA
☐ 2389	CDHR1 Comprehensive (Seq. & Del/Dup Analysis)	Cone-Rod Dystrophy 15	BE, DNA
☐ 2849	CRB1 Comprehensive (Seq. & Del/Dup Analysis)	CRB1-Related Disorders	BE, DNA
☐ 5280	OAT Sequence Analysis	Gyrate Atrophy of Choroid and Retina	BE, DNA
☐ 2789	IMPDH1 Comprehensive (Seq. & Del/Dup Analysis)	IMPDH1-Related Disorders	BE, DNA
☐ 2394	LCA5 Comprehensive (Seq. & Del/Dup Analysis)	LCA5-Related Disorders	BE, DNA

* Refer to Sample Specifications Table (page 5)

Contiued on next page

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SINGLE GENE ANALYSIS CONTINUED

TEST CODE	TEST NAME	DISORDER	SAMPLE TYPE*
☐ 6039	OCRL Sequence Analysis	Lowe Syndrome	BE, DNA
☐ 2839	LRAT Comprehensive (Seq. & Del/Dup Analysis)	LRAT-Related Disorders	BE, DNA
☐ 6083	X-Linked, GPR143 Comprehensive (Seq. & Del/Dup Analysis)	Oculocutaneous Albinism	BE, DNA
☐ 3529	Type 3, OPA3 Comprehensive (Seq. & Del/Dup Analysis)	Optic Atrophy	BE, DNA
☐ 2414	ABHD12 Comprehensive (Seq. & Del/Dup Analysis)	Polyneuropathy, Hearing Loss, Ataxia, Retinitis Pigmentosa, and Cataract Disorder	BE, DNA
☐ 2959	RDH12 Comprehensive (Seq. & Del/Dup Analysis)	RDH12-Related Disorders	BE, DNA
☐ 2974	EYS Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE, DNA
☐ 2994	FAM161A Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE, DNA
☐ 2984	MERTK Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE, DNA
☐ 2459	PDE6B Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE, DNA
☐ 2399	PROM1 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE, DNA
☐ 2939	PRPH2 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE, DNA
☐ 2479	RGR Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE, DNA
☐ 2449	RP2 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE, DNA
☐ 2359	RPGR Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE, DNA

* Refer to Sample Specifications Table (page 5)

Contiued on next page

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SINGLE GENE ANALYSIS CONTINUED

TEST CODE	TEST NAME	DISORDER	SAMPLE TYPE*
☐ 2934	RPE65 Comprehensive (Seq. & Del/Dup Analysis)	RPE65-Related Disorders	BE, DNA
☐ 2899	PRKCG Comprehensive (Seq. & Del/Dup Analysis)	Spinocerebellar Ataxia 14 (SCA)	BE, DNA
☐ 6650	USH2A Sequence Analysis	USH2A-Related Disorders	BE, DNA

* Refer to Sample Specifications Table below

SAMPLE SPECIFICATIONS TABLE

ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT		SHIPPING INSTRUCTIONS	SPECIAL NOTES
		(2 YRS - ADULT)	(NEWBORN - 2 YRS)		
BE	Blood in EDTA tube (purple-top)	3 - 5 cc	3 cc	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	For clarification or follow-up of CMA results, sodium heparin (green top) tubes are highly recommended. Send 3 - 5 cc (adults/children) and 1 - 2 cc (infant<2 years).
CF	Cultured Skin Fibroblast	2 T25 flasks		Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	Send 2 T25 flasks at 80 - 100% confluence
DNA	DNA, Extracted	At least 20 ug of purified DNA		Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	Minimal concentration of 50 ng / uL; A260 / A280 of ~1.7 - 2.0
SA	Saliva	See Special Notes		Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	Collected with Oragene•DX DNA Self-Collection Kit
T	Tissue	50 mg		Ship frozen sample in insulated container with 3 - 5 lbs. of dry ice by overnight courier.	Tissue should be flash frozen in liquid nitrogen at collection with no media added, and stored at -80° C.
SB	Skin Biopsy	$5mm^3$		Ship at ambient temperature (18-25° C / 64-77° F). Protect paraffin tissue from excessive heat. Ship in cooled container during summer months.	Collect skin from a central location (e.g., buttock or upper thigh) rather than from a distal location (e.g., foot) to enhance cell viability. Place sample in a separate sterile container with RPMI media. In the absence of RPMI media, place sample in a sterile container with a small amount of sterile saline. Unacceptable Conditions: Specimens placed in formalin or other fixatives.

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INFORMED CONSENT FOR INHERITED EYE DISORDERS TESTING

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

GENERAL GENETIC TESTING CONSENT

This consent form cannot be used for whole exome sequencing (WES), whole genome sequencing (WGS), biochemical testing, or Huntington disease testing. Consent forms for other tests are located at Baylor Genetics' website (https://www.baylorgenetics.com/consent/).

For the purposes of this consent, "I", "my", "you", and "your" can refer to you, your child, your unborn child, or other individual you are the legal representative of.

TEST INFORMATION

Your healthcare provider (doctor, genetic counselor, or other person with medical training) wants to order one or more tests to find a cause for your health issues. This testing can see if there is a cause for your health issues or if there is an increased chance for a health issue to happen to you or your family. Some of these tests look for changes, called variants, in a person's DNA. DNA is our genetic material. You might have testing for variants in one or more genes, specific parts of DNA that are needed for our health. Variants can also be found in other places in the genome (all of the DNA that a person has). Some tests might look for changes in proteins or analytes that cause health issues. The testing ordered will depend on your health issues as well as what is already known about you and your family's genetics. These tests may also explain health issues that your family may have. Even if this test finds the cause of your health issues, this may not help treat or manage those issues.

Before you sign this consent form, you should speak with your healthcare provider. They can help you understand this testing and what it means for your health.

TEST RESULTS

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

- **Positive:** A variant in the DNA was found that is related to your health issues or a health issue that you are at an increased risk of having in the future. These changes that cause disease are also known as pathogenic variants.
- **Negative:** No variants in the DNA were found that are related to your health issues or that would increase your risk of a health issue in the future.
- **Variant of Uncertain Clinical Significance (VUS):** A variant in the DNA was found that we do not know its effect, if any, on health. More testing may be needed for you or your family if a VUS is found that may be associated with your health issues.
- **Secondary and Incidental Findings:** Testing can sometimes find a variant in the DNA not related to the reason for testing. If this result is expected to affect your health, it is called a secondary or incidental finding.

CONSIDERATIONS AND LIMITATIONS

- You should speak with your provider before signing this consent form to understand the risks, benefits, and alternatives to testing.
- Testing may show you have, or are at increased chance of having, a health issue. It may show that you have an increased chance of having a child with a health issue.
- Even if the variant(s) causing your health issues are found, how these issues might progress or improve with treatment might not be known. Affected family members with the same variant might not be affected like you are.
- Depending on the results of testing, more testing may be needed to understand these results. This testing might be needed for you and/or other family members.
- A negative result does not rule out the chance for health issues. Our knowledge of variants and how they cause disease may change over time as we learn more about genetics. Testing has limitations to what it can find as well.
- Certain factors may lead to incorrect results. These include mislabeled samples, incorrect information in the test order, and rare technical errors.
- More sample may be needed from you if the first sample is not sufficient to complete testing.

PATIENT CONFIDENTIALITY AND SAMPLE RETENTION

- If several family members are tested, knowing the correct biological relationships among them is important. In rare cases, testing can show that family members are not related as expected. If this is found, we may contact the provider who ordered your testing.
- If this testing is requested to be cancelled after the order and sample are sent to the laboratory, please see our Test Cancellation Policy at www.baylorgenetics.com/cancel-test/.
- Only Baylor Genetics and its contracted partners will have access to your sample for the ordered testing. Results from testing will only be released to: (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. You have the right to access your test results from Baylor Genetics by providing a written request. You also have the right to request raw data obtained from your sample by providing a written request or HIPAA Authorization Form.
- In rare cases, people with genetic diseases may have problems with health insurance and employment. The U.S. Federal Government has several laws that prohibit discrimination based on test results by health insurance companies and employers. These laws also prohibit unauthorized disclosure of this information. For more information, please visit www.genome.gov/10002077.
- Samples will be kept in the laboratory based on our retention policy. Once testing completes, de-identified sample may be used for test development, quality assurance, and training purposes. Samples are not returned to patients or providers unless requested prior to testing. You and your heirs will not receive payments, benefits, or rights to any resulting products or discoveries.
- The information from your testing may be used in scientific research, publications or presentations, but your specific identity will not be revealed. We may contact your provider to obtain more clinical information about you. Baylor Genetics also performs other types of scientific research and may contact you to see if you would like to be involved.
- Variants found may be submitted to databases. The medical community uses these databases to collect information about how variants might cause disease to improve testing and treatment for patients. An example is ClinVar, a free, public archive of reports on human genetics. Limited clinical information may need to be shared with these databases. In rare cases, this information may be enough to allow you or your family members to be identified.
- For more information on privacy practices at Baylor Genetics, please visit www.baylorgenetics.com/privacy-practices/.

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			/ /	

FOR SAMPLES FROM NEW YORK STATE RESIDENTS

Samples from New York State residents shall not be included in research without written consent. Samples will not be retained for more than sixty (60) days after receipt by Baylor Genetics, unless authorized by marking below. No tests other than those authorized shall be performed on the samples.

☐ I authorize Baylor Genetics to retain sample(s) longer based on our retention policy for test development, quality assurance, and training purposes.

FINANCIAL AGREEMENT

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. I 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. Please note, some payers may not cover certain screening tests.

If my health insurer does not cover the test or I do not have health insurance, I have received a good faith estimate of the cost for the genetic testing ordered by my provider and agree to pay for the cost of the genetic testing billed to me by Baylor Genetics based on that good faith estimate. More information is available in Baylor Genetics' No Surprises Act and Good Faith Estimate Notice located at https://www.baylorgenetics.com/no-surprises-act/.

A Medicare Advance Beneficiary Notice (ABN) is required for services Medicare identifies as not medically necessary.

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

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

*If you are signing on behalf of the patient as the parent(s) and/or person with legal authority to act on behalf of the patient or parent, you may be required to provide evidence of your authority.