

**SEQUENTIAL TRIO WHOLE EXOME SEQUENCING REQUISITION (TEST CODE: 1601)**
**FASCIMILE INFORMATION**

From \_\_\_\_\_ Date (MM / DD / YYYY) \_\_\_\_\_ # Pages \_\_\_\_\_

**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) ICD10 Diagnosis Code(s) (Required)  
 3. Name of Ordering Physician 4. Insured Signature of Authorization

 Commercial  Medicaid  Medicare\*

\*A completed Advance Beneficiary Notice (ABN) is required for Medicare patients that do not meet Medicare criteria.

Has the patient been a hospital inpatient in the last 14 days?

 No, the patient was not an inpatient  Yes, the patient was an inpatient (hospital stay longer than 24 hours)

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 # _____
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 _____	

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. If self-pay is selected, I agree to pay for the cost of testing ordered and billed by Baylor Genetics as outlined in the Good Faith Estimate I received. 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, Medicare may not cover certain screening tests.

Patient / Guardian Printed Name \_\_\_\_\_ Patient / Guardian Signature \_\_\_\_\_ Date (MM / DD / YYYY) \_\_\_\_\_

**SEQUENTIAL TRIO WHOLE EXOME SEQUENCING REQUISITION (TEST CODE: 1601)**

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

**TEST INFORMATION**

This testing is ONLY available as a follow up for Proband WES (test code 1500) Version 3. Version 3 began being offered in September 2014 and the version number is indicated on the WES report. If you are uncertain which WES version number was completed, please call client services to verify. If you had a version 1 or 2 Proband WES run previously, please consider ordering Trio WES (test code 1600). Please see website, www.baylorgenetics.com, for further details and requisition.

**BIOLOGICAL PARENTS INFORMATION**

BIOLOGICAL PARENTS SAMPLES ARE REQUIRED FOR SEQUENTIAL TRIO WES TESTING. TESTING CANNOT BE INITIATED UNTIL BOTH PARENTAL SAMPLES HAVE BEEN RECEIVED. PLEASE SHIP TOGETHER.

- If samples have been previously submitted to the laboratory as part of Proband WES testing (1500) please call client services to see if previous sample is sufficient. If parental saliva sample was sent previously, this sample type is not acceptable for this testing (1551). Please submit a blood sample as instructed below.
- If parental samples have NOT been previously submitted include a copy of this form with submission of their samples. As instructed above a copy must also be faxed to 713-798-2787. Send 10 cc blood in EDTA tube. Be sure to label parental samples with full name and date of birth of parent - DO NOT LABEL WITH CHILD'S NAME.

**MATERNAL INFORMATION**

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Maternal Last Name                      Maternal First Name                      MI                      Maternal Date of Birth (MM / DD / YYYY)

Sample previously submitted?                      SAMPLE TYPE:                       NO, Please fill out sample information below.                       YES, Baylor Genetics Lab #: \_\_\_\_\_

Asymptomatic                      SAMPLE TYPE:                       Blood                      \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_                       Not Available  
 Symptomatic (Attach summary of findings)                       Saliva                      Date of Collection (MM / DD / YYYY)                       To Be Sent Later \*  
 Buccal Swab

**PATERNAL INFORMATION**

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Paternal Last Name                      Paternal First Name                      MI                      Paternal Date of Birth (MM / DD / YYYY)

Sample previously submitted?                      SAMPLE TYPE:                       NO, Please fill out sample information below.                       YES, Baylor Genetics Lab #: \_\_\_\_\_

Asymptomatic                      SAMPLE TYPE:                       Blood                      \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_                       Not Available  
 Symptomatic (Attach summary of findings)                       Saliva                      Date of Collection (MM / DD / YYYY)                       To Be Sent Later \*  
 Buccal Swab

**ADDITIONAL REPORTING OPTIONS**

If a box is not checked the lab will default to No / Not Report.

**Option for Reporting of ACMG Secondary Findings**

Variants in genes included in the ACMG secondary findings guidelines will be reported for each family member marked below. Each marked family member will receive their own report on these findings.

- Proband                       Mother                       Father                       Other Family Member

**Option for Reporting of Incidental Findings**

Pathogenic and likely pathogenic variants in genes covered under Category II of the Incidental Findings section of the consent form will be reported.

- Please report pathogenic and likely pathogenic variants in genes associated with Incidental Findings.

**Trio and Quad Orders with Both Parents Only – Option for Reporting of Research Findings**

For variants in genes with no known disease association, these variants will be reported if biallelic or de novo.

- Please report biallelic and de novo variants in genes with no known disease association.

**ITEM CHECKLIST**

- Maternal Sample (EDTA or Saliva)                       Consent Form Signed By All Individuals Tested                       Updated Clinical Notes/Summary  
 Paternal Sample (EDTA or Saliva)                       Updated Indication for Study Checklist                       Pedigree  
 Requisition

**SEQUENTIAL TRIO WHOLE EXOME SEQUENCING REQUISITION (TEST CODE: 1601)**

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

**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 whole exome sequencing 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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**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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Patient Last Name \_\_\_\_\_ Patient First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth (MM / DD / YYYY) \_\_\_\_\_ Genetic Sex \_\_\_\_\_

**INDICATION FOR TESTING (REQUIRED) - CONTINUED**

<b>ENDOCRINE</b> ..... <input type="checkbox"/> 0000819 Diabetes Mellitus <input type="checkbox"/> 0000873 Diabetes Insipidus <input type="checkbox"/> 0000821 Hypothyroidism <input type="checkbox"/> 0000829 Hypoparathyroidism <input type="checkbox"/> 0000834 Abnormality of the Adrenal Glands <input type="checkbox"/> 0001738 Exocrine Pancreatic Insufficiency <input type="checkbox"/> 0002721 Immunodeficiency <input type="checkbox"/> _____ <input type="checkbox"/> _____	<b>HEMATOLOGY</b> ..... <input type="checkbox"/> 0001875 Neutropenia <input type="checkbox"/> 0005549 Congenital <input type="checkbox"/> Chronic <input type="checkbox"/> Cyclic <input type="checkbox"/> 0001873 Thrombocytopenia <input type="checkbox"/> 0040185 Macrothrombocytopenia <input type="checkbox"/> 0005537 Decreased Mean Platelet Volume <input type="checkbox"/> 0005518 Erythrocyte Macrocytosis <input type="checkbox"/> 0004444 Spherocytosis <input type="checkbox"/> 0012410 Pure Red Cell Aplasia <input type="checkbox"/> Aplastic <input type="checkbox"/> Hypoplastic <input type="checkbox"/> 0001903 Anemia <input type="checkbox"/> 0005528 Bone Marrow Hypocellularity <input type="checkbox"/> _____ <input type="checkbox"/> _____	<b>OTHER</b> ..... <input type="checkbox"/> Organomegaly <input type="checkbox"/> Chronic Infections <input type="checkbox"/> 0004311 Abnormality of Macrophages <input type="checkbox"/> 0001954 Episodic Fever <input type="checkbox"/> 0004313 Hypogammaglobulinemia <input type="checkbox"/> 0010701 Abnormal Immunoglobulins <input type="checkbox"/> 0002721 Immunodeficiency <input type="checkbox"/> 0012088 Abnormal urinary odor <input type="checkbox"/> 0012537 Food intolerance <input type="checkbox"/> 0008067 Abnormally lax or hyperextensible skin <input type="checkbox"/> Abnormal Movements <input type="checkbox"/> Family History of Similar Disorder <input type="checkbox"/> 0001254 Lethargy <input type="checkbox"/> 0002415 Leukodystrophy <input type="checkbox"/> _____ <input type="checkbox"/> _____
<b>EAR DEFECTS &amp; HEARING</b> ..... <input type="checkbox"/> 0000407 Sensorineural Hearing Impairment <input type="checkbox"/> 0008619 Bilateral <input type="checkbox"/> 0000405 Conductive Hearing Impairment <input type="checkbox"/> 0000410 Mixed Hearing Impairment <input type="checkbox"/> 0004467 Preauricular Pit <input type="checkbox"/> 0000384 Preauricular Skin Tag <input type="checkbox"/> 0000369 Low-set Ears <input type="checkbox"/> 000037 Abnormality of the Pinna <input type="checkbox"/> _____ <input type="checkbox"/> _____	<b>CANCER</b> ..... <input type="checkbox"/> Type of Cancer _____ <input type="checkbox"/> Age of Diagnosis _____ <input type="checkbox"/> Family History of Cancer and Affected Relatives _____ _____ _____	<b>GENES OF INTEREST</b> ..... _____ _____ _____ _____

**ADDITIONAL CLINICAL INFORMATION**
**DIFFERENTIAL DIAGNOSIS**

Consent on next page

**INFORMED CONSENT FOR SEQUENTIAL TRIO WHOLE EXOME SEQUENCING (TEST CODE: 1601) TESTING**

Patient Last Name

Patient First Name

MI

Date of Birth (MM / DD / YYYY)

Genetic Sex

**WHOLE EXOME SEQUENCING (WES) AND WHOLE GENOME SEQUENCING (WGS) CONSENT**

This consent form can only be used for whole exome sequencing and whole genome sequencing. 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 a genetic test called Whole Genome Sequencing (WGS) or Whole Exome Sequencing (WES). These tests look for changes, called variants, in a person's DNA that can cause health issues. DNA is our genetic material. These variants can be in certain genes, specific parts of our DNA that are needed for our health. They can also be found in other places in the genome (all DNA that a person has). Based on your known health issues, variants in your DNA that may cause these issues will be reported. This test may explain your health issues. It 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.

Testing where your DNA is compared to one or more family members may be performed. This may help better understand your results or show if your family members have the same variant as you.

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 (Optional):** Testing can sometimes find a variant in the DNA not related to the reason for testing but can change your medical care. **Note:** Certain issues within the brain start in adulthood and get worse over time (neurodegenerative). They often have no cure or treatment. By default, these variants will not be reported unless they are related to your health issues. However, variants in one or more of these gene(s) can be requested if needed. Your provider must write each gene needed in your test order.
- **Genes of No Known Disease Association (Optional):** Testing may find a variant in a gene that is not known to cause disease. This may be helpful to learn more about these genes in the future. These results do not currently impact medical management or indicate a diagnosis.

**SECONDARY AND INCIDENTAL FINDINGS**

The following categories of variants are not expected to cause your current health issues. However, they can each be requested to be reported. Knowing about these variants might affect your future medical care.

- **ACMG Secondary Findings:** The American College of Medical Genetics and Genomics (ACMG) recommends reporting disease-causing variants in certain genes that cause health issues. Each family member can request this group of variants to be reported.
- **Incidental Findings:** Other variants known to cause health issues but that are not causing your current health issues.

**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.

**USE OF DATA AND SPECIMEN FOR RESEARCH PURPOSES**

Biological specimens, test results, and associated information may be used by Baylor Genetics and its research partners for anonymous or coded research purposes, including improving genetic testing, advancing knowledge of genetic conditions, and developing new technologies, including inclusion in de-identified clinical databases, only with the patient's informed consent. Patient data and specimen will not be used for anonymous or coded research, unless authorized by marking below. A patient's decision to decline participation shall not affect their ability to receive testing from Baylor Genetics.

For Oregon patients, please consult the state specific consent form found at [www.baylorgenetics.com/forms](http://www.baylorgenetics.com/forms).

I authorize Baylor Genetics the use of my specimen and de-identified data for research.

**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.

**INFORMED CONSENT FOR SEQUENTIAL TRIO WHOLE EXOME SEQUENCING (TEST CODE: 1601) TESTING**

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

**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/](http://www.baylorgenetics.com/cancel-test/).

**PATIENT CONFIDENTIALITY AND SAMPLE RETENTION (CONTINUED)**

- 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](http://www.genome.gov/10002077).
- Samples will be kept in the laboratory based on our retention policy. Once testing is completed, the 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/](http://www.baylorgenetics.com/privacy-practices/).

**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).

**Note: If Prenatal WES was ordered, please leave the Patient section blank and complete only a section for each relative tested below.**

I hereby give permission to Baylor Genetics to conduct genetic testing as recommended by my healthcare provider.\*

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

Relationship to Patient	Name	Signature	Date
Relative 1	_____	_____	_____
Relative 2	_____	_____	_____
Relative 3	_____	_____	_____

**If one or more family members have a Representative signing on their behalf:**

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Name                      Signature                      Date (MM / DD / YYYY)                      Representative For                      Relationship to Represented Person(s)

\*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.

**INFORMED CONSENT FOR SEQUENTIAL TRIO WHOLE EXOME SEQUENCING (TEST CODE: 1601) TESTING**

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

**FOR SURROGATES PREGNANCIES – FOR PRENATAL WES ONLY:**

Maternal cell contamination (MCC) studies use blood or another sample from a pregnant person. MCC studies are used to determine that the sample being tested belongs to the fetus and not the pregnant person. The results of MCC studies are not used for the treatment or management of the fetus, pregnant person, or other individuals, and are not part of the pregnant person's designated medical record.

I hereby give permission for my sample to be used for MCC studies:

\_\_\_\_\_  
Surrogate Name                      Surrogate Signature                      Date Signed (MM / DD / YYYY)

**A. Ordering Physician Name:** \_\_\_\_\_

**B. Patient Name:** \_\_\_\_\_ **C. Identification Number:** \_\_\_\_\_

### Advance Beneficiary Notice of Non-coverage (ABN)

**NOTE: If Medicare doesn't pay for a Baylor Genetics test below, you may have to pay.**

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for one or more of the **Baylor Genetics test(s)** below.

D. Laboratory Tests	E. Reason Medicare May Not Pay:	F. Estimated Cost
Sequential Trio WES	Medicare does not pay for this test for your condition.	\$1,300

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **Baylor Genetics test** listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

<p><b>G. OPTIONS: Check only one box. We cannot choose a box for you.</b></p>
<input type="checkbox"/> <b>OPTION 1.</b> I want the <b>Baylor Genetics Test</b> listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
<input type="checkbox"/> <b>OPTION 2.</b> I want the <b>Baylor Genetics Test</b> listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
<input type="checkbox"/> <b>OPTION 3.</b> I don't want the <b>Baylor Genetics Test</b> listed above. I understand with this choice I am <b>not</b> responsible for payment, and I cannot appeal to see if Medicare would pay.

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You may ask to receive a copy.

<b>I. Signature:</b> _____	<b>J. Date:</b> _____
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**You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit [Medicare.gov/about-us/accessibility-nondiscrimination-notice](https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice).**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.