TEST REQUEST FORM
CASCADE TESTING

*** Mandatory fields**

PATIENT DETAILS

Forename* _____

Surname* _____

Biological Sex* _____

DOB (DD/MM/YYY)* _____

Hospital ID _____

Ancestry[1]

☐ European (non-Finnish) ☐ Admixed American
☐ European (Finnish) ☐ African/African American
☐ East Asian ☐ Ashkenazi Jewish
☐ South Asian ☐ Middle Eastern
☐ Amish ☐ Other _____

[1]As defined by the Genome Aggregation Database (gnomAD).

HEALTH PRACTITIONER DETAILS

Account ID _____
Full Name* _____
Phone _____
Email _____
Institution* _____

Address 1 _____
Address 2 _____
City/town _____
Post Code _____
Country _____

TEST DETAILS

Was the Index (familial) patient tested at Genseq?* ☐ Yes ☐ No / Not known

If Yes:

- Index Patient's Name*: _____
- Genseq ID*: _____
- Index Patient's DOB (DD/MM/YYY)*: _____

If Index was NOT tested at Genseq, please attach a copy of Index (Familial) report* ☐

Additionally, where possible, please send a whole blood sample (EDTA Tube) or Genomic DNA (Source:_____) from the Index with this request form.

Index phenotype*

Age of Onset* _____ Diagnosis/ Symptoms*[1] _____

Relationship between the person being tested and the index patient*

*The person being tested is the index patient's: _____

(e.g. brother, sister, son, daughter, mother, father)

CLINICAL INFORMATION

Reason for testing* ☐Predictive ☐ Carrier ☐ Segregation ☐Other:_____

Clinical details (affected/unaffected)[1]

_____

_____

_____

[1]Detailed clinical information significantly improves the interpretation of identified variants. Please use HPO terms, where possible: ***https://hpo.jax.org/app***

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VARIANT TO BE TESTED

	Gene (e.g. *TTN*)	Transcript (NM_001256850.1)	cDNA change (e.g. c.102917T>A)	Protein Change (e.g. p.(Ile34306Asn))
Variant 1				
Variant 2				
Variant 3				

SAMPLE DETAILS

Sample Type* ☐ Whole Blood (EDTA Tube) ☐ Genomic DNA, **Source:** _____

☐ Saliva (Oragene Tube) ☐ Buccal Swab

Date Collected (DD/MM/YYY)* _____ **Time Collected (hh:mm)** _____

CONSENT

***Please, indicate how long you would like Genseq to store DNA sequencing raw data on your behalf:**

☐ **6 months** (default retention time where no option is chosen) ☐ **12 months**

In addition, in order to (a) fulfil your instructions to the requested perform genetic testing, and (b) for us to provide further cascade genetic tests for you, each as undertaken in the context of an accredited genetic testing service, you understand that other data types, such as patient data received on this Test Request Form, laboratory QC data and report data will be stored for a further period of years taking account of applicable law, regulation and industry guidance. In returning this Test Request Form for processing you are instructing us in writing to undertake such processing on your behalf.

☐ ***I hereby confirm that I have obtained written informed consent from the patient for this test to be performed, including consent for health practitioners registered under my account to access the report.**

BILLING AND REPORT DETAILS

The invoice for this test will be sent to the default billing address associated with your Account ID. If your institution requires a PO number, please insert it here.

PO Number _____

☐ Patient Self Pay Patient phone number: _____ Patient email : _____

The report for this test will be made available in your account on Genseq's online ordering portal. If you need other health practitioners to have access to the report, please ensure they are registered under your account to ensure appropriate communication

INTERNAL USE ONLY

Sample ID _____