TEST REQUEST FORM
GENE PANEL

*** mandatory fields**

PATIENT DETAILS

Forename* _____ **Surname*** _____

Hospital ID _____ **DOB (DD/MM/YYY)*** _____

Biological Sex* _____

HEALTH PRACTITIONER DETAILS

Account ID* _____ **Address 1*** _____

Full Name* _____ **Address 2** _____

Phone* _____ **City/town*** _____

Email* _____ **County/ State*** _____

Institution* _____ **Post Code*** _____

Country* _____

TEST DETAILS

Gene Panel to be analysed*[1]

Cardiology

- ☐ Arrhythmogenic right ventricular cardiomyopathy panel
- ☐ Brugada syndrome-Core panel
- ☐ Brugada syndrome-Expanded panel
- ☐ Catecholaminergic polymorphic ventricular tachycardia panel
- ☐ Comprehensive cardiac arrhythmias panel
- ☐ Comprehensive Cardiomyopathy panel
- ☐ Dilated cardiomyopathy and conduction defects-Core panel
- ☐ Dilated cardiomyopathy and conduction defects-Expanded panel
- ☐ Dyslipidaemia (includes Familial Hypercholesterolaemia) panel
- ☐ Hypertrophic Cardiomyopathy-Core panel
- ☐ Hypertrophic Cardiomyopathy-Expanded panel
- ☐ Left Ventricular Noncompaction Cardiomyopathy panel
- ☐ Long QT syndrome-Core panel
- ☐ Long QT syndrome-Expanded panel
- ☐ Short QT syndrome panel
- ☐ *TTR* single gene

Hereditary Cancer

- ☐ Hereditary Cancer *BRCA1 / BRCA2*
- ☐ Hereditary Breast and Gynaecological Cancer Panel
- ☐ Hereditary Colorectal Cancer and Polyposis Panel
- ☐ Hereditary Breast Cancer Panel
- ☐ Hereditary Cancer - Lynch Syndrome

[1]Please refer to our Laboratory User Guide for information on the sample requirements for this test, and refer to our Gene Panel webpage for the contents of each gene panel. Gene panels are based on Whole Exome Sequencing data. Only genes on the panels are analysed after applying a computational filter (in silico analysis). All pathogenic and likely pathogenic variants identified on genes on the panel will be reported. Variants of unknown significance (VUS), likely benign and benign will not be reported. Single heterozygous variants in genes associated with autosomal recessive inheritance may not be reported.

CLINICAL INFORMATION

Referral Reason*[1] _____

_____

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

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PATIENT'S FAMILY HISTORY

Mother's Ancestry

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

Father's Ancestry

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

Are the patient's parents consanguineous? ☐ Yes ☐ No ☐ Unknown

Are there other family members who currently have or have had the same or a similar phenotype as the patient? ☐ Yes ☐ No

If yes, please list the affected members below:

Relationship to the Patient (e.g., mother, brother, uncle)	Age of Onset	Diagnosis/ Symptoms

SAMPLE DETAILS

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

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

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 _____

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.

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

☐ **6 months** ☐ **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.**

INTERNAL USE ONLY

Sample ID _____