TEST REQUEST FORM

SoloSEQ

GENSEQ

Single Gene Test

*Mandatory fields

PATIENT DETAILS

Forename* _____

Surname* _____

Biological Sex* _____

Hospital ID _____

DOB (DD/MM/YYYY)* _____

Ancestry[1]

- ☐ European
- ☐ Central/South Asian
- ☐ East Asian
- ☐ Sub-Saharan African
- ☐ Latino
- ☐ African American /Afro-Caribbean
- ☐ Other _____

1 As defined by the Clinical Pharmacogenetics Implementation Consortium (CPIC)

TEST DETAILS

Gene to be analysed*[2]

- ☐ ***DPYD* gene variants**
  (*2A (c.1905+1A>G), *13 (c.1679T>G), HapB3 (c.1236G>A) and c.2846A>T)
- ☐ ***TPMT* gene variants**
  (*2 (c.238G>C), *3B (c.460G>A) and *3C (c.719A>G))
- ☐ **C *YP2C19* gene variants**
  (*2, *3, *17)
- ☐ ***HFE* gene variants**
  (p.(Cys282Tyr) and p.(His63Asp))

2 Please refer to our Laboratory User Guide for information on the sample requirements for this test.

CLINICAL INFORMATION

Referral Reason

_____

_____

_____

_____

_____

_____

HEALTH PRACTITIONER DETAILS

Account ID _____

FullName* _____

Phone _____

Email _____

Institution* _____

Address 1 _____

Address 2 _____

City/town _____

Post Code _____

Country _____

SAMPLE DETAILS

Sample Type

- ☐ Whole Blood (EDTA Tube)
- ☐ Genomic DNA

Source: _____

Date Collected (DD/MM/YYYY)* _____

Time Collected (HH:MM) _____

CONSENT

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

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

In addition, in order to fulfil your instructions to perform the genetic testing 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 _____

Genseq Group
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