Variantyx

Genomic Unity®
Lightning Genome Analysis
Test Requisition Form
Page 1 of 1

Patient Name		Affix barcode label of Patient's sample here
Date of Birth		

Required Information Checklist:

- ❑ **Patient demographics**
- ❑ **ICD-10 codes**
- ❑ **Healthcare provider signature**
- ❑ **All previous testing results for example: newborn screening, metabolic screening, other genetic tests**
- ❑ **Clinical & genetic counseling notes with pedigree**
- ❑ **Completed TRF and all clinical notes faxed to 508-302-0528**
- ❑ **Letter of medical necessity and/or required insurance forms if applicable**

Clinical Information

ICD-10 Code(s)*	Suspected Diagnosis
Has the patient had previous genetic testing? Yes / No	***If yes please include copies of the reports.**

Testing Options:

◯ Genomic Unity® Lightning Genome Analysis ◯ Option to receive ACMG Secondary Findings

Healthcare Provider's Statement

By my signature below, I attest that I am the referring physician, an authorized healthcare provider for the patient or procurator thereof, and this testing is medically necessary for diagnosis and/or treatment of the patient. I attest that the patient or guardian has voluntarily consented to genetic testing for diagnostic purposes, including possible results and outcomes, ACMG secondary findings, if selected, has been given the opportunity to ask questions about the testing and/or seek genetic counseling, and agrees to allow an independent genetic counselor facilitated through a third party to provide pre-test and/or post-test genetic counseling if required by the insurer and/or referring institution.

Healthcare provider signature _____ Date _____

Patient Information

First Name	Last Name	MI	DOB	Genetic Sex ◯ Male ◯ Female ◯ Other _____
Address		ID / MR#		Gender identification (optional):
City	State	Zip Code	Phone	Email
Other Name (if different than listed above): ◯ Please use this name in communications.			Pronouns	Preffered language ◯ English ◯ Spanish

Patient Sample Information

Sample Type ◯ Blood * *Use Variantyx collection kits only*	Collection date	Please check if your patient has had a: *We will contact you for additional specimen collection details.*	◯ Bone marrow transplant ◯ Blood transfusion within the last two weeks

Comparator Information 1

First Name	Last Name	Relationship to Proband	DOB	Date of sample collection	Genetic Sex ◯ M ◯ F ◯ Other _____
Address Phone Email		If affected by the same disorder as the patient please list the clinical symptoms:			Gender identification (optional):

Comparator Information 2

First Name	Last Name	Relationship to Proband	DOB	Date of sample collection	Genetic Sex ◯ M ◯ F ◯ Other _____
Address Phone Email		If affected by the same disorder as the patient please list the clinical symptoms:			Gender identification (optional):

Ordering Healthcare Provider

First Name	Last Name	Facility Name	NPI #
Facility Address		Phone	Email
Contact number for questions	City	State Zip Code	Fax

Additional Report Recipients

Name	Phone	Fax	Email
Name	Phone	Fax	Email

Billing Information

◯ Institutional Billing	◯ Patient Payment
An invoice will be sent to the institution listed above. Please contact us for alternate billing.	An invoice will be sent to the patient email provided. Insurance will not be billed.
Contact person (billing):	

Variantyx

Genomic Unity®
Lightning Genome Analysis
Supplement A
Patient Phenotype

Patient Name	
Date of Birth	

Affix barcode label of Patient's sample here

Patient Phenotypes

	1°	2°	Phenotype	Age of onset
Development/Behavior	◉	◉	Developmental regression	
	◉	◉	Global developmental delay	
	○	○	Intellectual disability	
	○	○	Delayed fine motor development	
	○	○	Delayed gross motor development	
	○	○	Delayed speech and language development	
	○	○	Speech articulation difficulties	
	○	○	Autism spectrum disorder	
	○	○	Self-injurious behavior	
	○	○	Stereotypy	
Brain Anomalies	○	○	Brain atrophy	
	○	○	Cerebellar hypoplasia	
	○	○	Cortical dysplasia	
	○	○	Encephalocele	
	○	○	Holoprosencephaly	
	○	○	Hydrocephalus	
	○	○	Lissencephaly	
	○	○	Molar tooth sign	
	○	○	Periventricular leukomalacia	
	○	○	Polymicrogyria	
Neurological	○	○	Abnormal nerve conduction velocity	
	○	○	Ataxia	
	○	○	Spasticity	
	○	○	Chorea	
	○	○	Dystonia	
	○	○	Foot dorsiflexor weakness	
	○	○	Headache	
	○	○	Neurodegeneration	
	○	○	Motor axonal neuropathy	
	○	○	Pes cavus	
	○	○	Reduced deep tendon reflexes	
	○	○	Seizures	
	○	○	Sleep apnea	
	○	○	Stroke-like episodes	
	○	○	Tremor	
	○	○	Vocal cord paresis	
Muscular	○	○	Dysphagia	
	○	○	Exercise intolerance	
	○	○	Hypertonia	
	○	○	Hypotonia	
	○	○	Muscle fasciculations	
	○	○	Muscle wasting	
	○	○	Muscle weakness	
	○	○	Muscular dystrophy	
	○	○	Myotonia	
Metabolic	○	○	Aciduria	
	○	○	Abnormal CPK circulation concentration	
	○	○	Decreased plasma carnitine	
	○	○	Elevated serum alanine aminotransferase	
	○	○	Increased serum pyruvate	
	○	○	Ketosis	
	○	○	Lactic acidosis	
Endocrine	○	○	Adrenal hyperplasia	
	○	○	Adrenal insufficiency	
	○	○	Cushing syndrome	
	○	○	Diabetes Mellitus Type I	
	○	○	Diabetes Mellitus Type II	
	○	○	Hypothyroidism	
	○	○	Hypoparathyroidism	
	○	○	Hypogonadism	
	○	○	Paraganglioma	

	1°	2°	Phenotype	Age of onset
Constitutional	◉	○	Cleft lip	
	○	○	Cleft palate	
	○	○	Syndactyly	
	○	○	Polydactyly	
	○	○	Failure to thrive	
	○	○	Macrocephaly	
	○	○	Microcephaly	
	○	○	Obesity	
	○	○	Short stature	
	○	○	Tall stature	
Ophthalmology/Auditory	○	○	Blindness	
	○	○	Cataracts	
	○	○	Coloboma	
	○	○	External ophthalmoplegia	
	○	○	Optic atrophy	
	○	○	Ptosis	
	○	○	Rod-cone dystrophy	
	○	○	Visual impairment	
	○	○	Aminoglycoside-induced hearing loss	
	○	○	External ear malformation	
	○	○	Hearing loss	
Cardiac	○	○	Arrhythmia	
	○	○	Cardiomyopathy	
	○	○	Syncope	
	○	○	Tetralogy of Fallot	
Gastrointestinal	○	○	Aganglionic megacolon	
	○	○	Constipation	
	○	○	Diarrhea	
	○	○	Elevated hepatic transaminases	
	○	○	Gastroesophageal reflux	
	○	○	Gastroschisis	
	○	○	Omphalocele	
	○	○	Pyloric stenosis	
	○	○	Tracheoesophageal fistula	
	○	○	Vomiting	
Genitourinary	○	○	Abnormal renal morphology	
	○	○	Ambiguous genitalia	
	○	○	Cryptorchidism	
	○	○	Hydronephrosis	
	○	○	Hypospadias	
	○	○	Renal agenesis	
Skeletal	○	○	Abnormal vertebral morphology	
	○	○	Clubfoot	
	○	○	Craniosynostosis	
	○	○	Multiple joint contractures	
	○	○	Scoliosis	
Skin	○	○	Abnormality of connective tissue	
	○	○	Abnormality of skin pigmentation	
	○	○	Abnormality of temperature regulation	
	○	○	Ichthyosis	
			Other phenotypes	

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