Variantyx

**Genomic Inform®**
Test Requisition Form
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| | |
|---|---|
| Patient Name | |
| Date of Birth | |

Affix barcode label of Patient's sample here

## Test order

◯ **Genomic Inform®**

Provides a whole genome sequence based test designed to identify variants that correlate with increased disease risk (e.g. genes related to cancer, cardiac conditions, late/adult onset disorders) and carrier status for autosomal or X-linked recessive diseases in a set of selected genes or variants in genes that are known to be pathogenic or likely pathogenic in other genes. This test includes sequence analysis (single nucleotide variants, deletions/insertions, characterized intronic and intergenic variants); analysis of copy number variants, duplications/deletions, mobile element insertions, inversions, and aneuploidy; mitochondrial genome sequence analysis with heteroplasmy and large deletions; and short tandem repeat expansion analysis in select genes.

◯ Option to receive Genomic Unity® Pharmacogenomics Analysis **(PG001)** **No selection will default to opt-out.*

## Ordering Healthcare Provider

| | | | |
|---|---|---|---|
| First Name | Last Name | | NPI # |
| Facility Name | | | Phone |
| Facility Address | | | Fax |
| City | State | Zip Code | Email |

## Additional Report Recipients

| | | | |
|---|---|---|---|
| Name | Phone | Fax | Email |
| Name | Phone | Fax | Email |

## Healthcare Provider's Statement

By my signature below, I indicate that I am the referring physician or authorized healthcare provider. I have explained the purpose of the test described above. The patient has been given the opportunity to ask questions and/or seek genetic counseling. The patient has voluntarily decided to have the test performed by Variantyx for screening purposes. I attest that the patient (or guardian) has voluntarily consented to testing performed by Variantyx through both oral and written consent.

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<br>◯ Saliva* ◯ Saliva swab*† ◯ Genomic DNA<br>◯ Assisted saliva* ◯ Blood ◯ Other:<br>* Use Variantyx collection kits only<br>† Saliva swab is similar to a buccal swab; Saliva swabs may have reduced sensitivity and specificity due to the presence of normal oral flora | Sample Will Be Collected<br>◯ In-house ◯ By Variantyx | Collection date |

Please check if your patient has had a: ◯ Blood transfusion within the last two weeks ◯ Bone marrow transplant

*We will contact you for additional specimen collection details.*

## 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. |

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