Variantyx Genomic Unity® Lightning Test Requision Form

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

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 1-508-302-0528
- ❍ Letter of medical necessity and/or required insurance forms if applicable.

*Missing or insufficient information will cause a delay in pre-authorization and results.

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 - Neonatal (RT010)**
❍ **Genomic Unity® Lightning Genome Analysis - Pediatric (RT020)**
❍ **Genomic Unity® Lightning Genome Analysis - Standard (RT030)**

❍ Option to receive ACMG Secondary Findings **No selection will default to opt-out.*
❍ Option to receive ACMG Secondary Findings with other actionable findings
**No selection will default to opt-out.*
❍ Option to receive Genomic Unity® Pharmacogenomics Analysis (PG001)
**No selection will default to opt-out. **This option is applicable for RT020 and RT030 only*

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, and pharmacogenomics analysis, 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 _____ Gender identification (optional):
Address			ID / MR#	
City	State	Zip Code	Phone	Email
Other Name (if different than listed above): ❍ Please use this name in communications.			Pronouns	Preffered language ❍ English ❍ Spanish

Comparator Information 1

First Name	Last Name	DOB	Relationship to proband	Genetic Sex ❍ Male ❍ Female ❍ Other _____ Gender identification (optional):
If affected by the same disorder as the patient please list the clinical symptoms				
Address			Phone	Email

Comparator Information 2

First Name	Last Name	DOB	Relationship to proband	Genetic Sex ❍ Male ❍ Female ❍ Other _____ Gender identification (optional):
If affected by the same disorder as the patient please list the clinical symptoms				
Address			Phone	Email

Ordering Healthcare Provider

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

Additional Report Recipients

Name	Phone	Fax	Email
Name	Phone	Fax	Email

Add GC or other healthcare provider(s)?

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Billing Information

❍ Institutional billing | ❍ Patient Payment *An invoice will be sent to the patient email provided. Insurance will not be billed.*

An invoice will be sent to the institution listed above.
Please contact us for alternate billing.

Who should be contacted for billing purposes?
Payer Name: Payer Phone: Payer Email:

Patient Sample Information

Sample Type ❍ Blood
*Use Variantyx collection kits only

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.