Variantyx Genomic Unity® Lightning Test Requisition 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*

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

Physician Attestation for Diagnostic Genetic Testing

By signing below, I attest that I am the referring physician or an authorized healthcare provider for the patient (or their legal representative/procurator), and that this genetic testing is medically necessary for the diagnosis and/or treatment of the patient.
I further attest that:
1. The patient or their guardian has voluntarily provided informed consent for genetic testing for diagnostic purposes, including the potential results and outcomes, ACMG secondary findings, other actionable findings, and pharmacogenomic analysis, if applicable and selected.
2. Any designated comparators have voluntarily consented to the use of their sample for testing, specifically for comparison to the patient's genetic data.
3. The patient and any designated comparators have consented to the use of their anonymized sample and clinical information to be used by Variantyx, their affiliates, and their partners to advance genetic testing and interpretation, validate results, confirm variants at an external lab, support quality assurance, contribute to variant and allele frequency databases and publications, and assist in training. The sample may also be used for research aimed at understanding genetic variations and identifying potential treatment targets. The names or any other personal identifying information will not be used in or linked to any databases or publications.
4. The patient, guardian, and comparators (if applicable) have been given the opportunity to ask questions about the testing and/or to seek genetic counseling.
5. The patient or guardian agrees to allow an independent genetic counselor, facilitated through a third party, to provide pre-test and/or post-test counseling if required by the referring institution or insurer.

Consent for Additional Uses

Contact Regarding Research Participation
The patient/guardian gives permission for Variantyx to contact me or my healthcare provider regarding potential **research studies and clinical trial participation**: ☐ Yes ☐ No

Health Information Exchange
The patient/guardian gives permission to share health information through the **Health Information Exchange (HIE) program**: ☐ Yes ☐ No

Healthcare provider signature _____ Date _____

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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.

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)?