Pediatric Exome Testing Supplemental Test Requisition Form

120 N. Pine St, Suite 152
Spokane, WA 99202
Phone: 844-ALLELE2 (255-3532)
Fax: 509-232-5779
Email: info@allelediagnostics.com

Patient Information

Name: First ________________________ MI ____ Last __________________________ Date of Birth (MM/DD/YYYY) ___________________

Medical Record Number ____ Sex: ☐ Male ☐ Female ☐ Unknown

Provider Information

Physician ______________________________________ Genetic Counselor ______________________________________

Phone ____________________ Fax ________________________ Email ______________________________________

Institution ______________________________________ Additional reports to ______________________________________

Specimen Information

☐ Peripheral blood (2-3 mL EDTA) Collection date (MM/DD/YYYY) ______________________ Time ______________________ ☐ am ☐pm

Mother Information (required if sending a sample for duo/trio testing)

Name: First ________________________ MI ____ Last __________________________ Date of Birth (MM/DD/YYYY) ___________________

Medical Record Number ____________________________ Ethnicity ______________________________ Sex: ☐ Male ☐ Female

Relevant clinical features ____

Sample: ☐ Peripheral blood (2-3 mL EDTA) Collection date (MM/DD/YYYY) ____________________ Time _________________ ☐ am ☐pm

Father Information (required if sending a sample for duo/trio testing)

Name: First ________________________ MI ____ Last __________________________ Date of Birth (MM/DD/YYYY) ___________________

Medical Record Number ____________________________ Ethnicity ______________________________ Sex: ☐ Male ☐ Female

Relevant clinical features ____

Sample: ☐ Peripheral blood (2-3 mL EDTA) Collection date (MM/DD/YYYY) ____________________ Time _________________ ☐ am ☐pm

Tests Ordered[1]

☐ 8910 Whole exome via NGS (Proband only)

  ☐ For 8910 only, please indicate if this order is a reflex from a negative panel performed through Allele. ADx #____________

☐ 8911 Whole exome via NGS (Trio with proband report and targeted testing of parents) ***Complete parental information sections above.***

☐ 8912 Whole exome via NGS (Trio with full parental reports) ***Complete parental information sections above.***

☐ 8915 Whole exome via NGS (Duo with full parental report) ***Complete applicable parental information section above.***

Incidental Findings (choose all that apply)

Incidental findings in parents are only reported if test #8912 or #8915 is ordered.

	Proband	Mother	Father
Medically actionable variants from ACMG recommended list of genes	☐	☐	☐
Variants not associated with current proband phenotype but associated with a Mendelian disorder	☐	☐	☐
Carrier status for autosomal recessive conditions	☐ (adults only)	☐	☐

Submission of consultation notes and pedigree is required.

Billing

Institutional Bill

Institution______________________________________ Contact Person ______________________________________

Address______________________________________ City, State, Zip______________________________________

Phone______________________ Email________________________________ Fax________________________

Credit Card Payment

Please call 844-ALLELE2 (255-3532) to pay by credit card.

Consent Verification

REQUIRED: I verify that I am a licensed/certified healthcare provider (or representative thereof) authorized to order genetic testing. I confirm that the patient has been informed of the benefits and limitations of the testing being ordered and has consented to the testing. Documentation of the informed consent is on file in the patient's medical record. I confirm that testing is medically necessary and that test results may impact medical management for the patient.

Signature of physician/healthcare provider/representative ____________________________________ Date ______________________

Use of Specimens: My (or my child's) sample may be stored indefinitely by Allele Diagnostics, Inc. for quality assurance, test validation, or educational purposes after personal identifiers are removed. I can withdraw my consent at any time by contacting the laboratory at 844-ALLELE2 (255-3532). Refusal to permit the use of my sample will not affect my test result. By checking this box ☐ I am indicating that the sample should be used for the tests ordered on this form and disposed of 60 days after testing is complete. All other samples will be retained based on disposal guidelines set forth by the state in which the ordering physician practices.

[1] *Testing performed by a partner laboratory.*

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