REQUISITION FORM 3B-EXOME PROBAND

SAMPLE CLINICAL USE ONLY

PATIENT INFORMATION

	Unique ID	Sex	Date of Birth	Ethnicity
Patient	<Unique ID>	Male	1990-10-10	East Asian

EPA23-XXXX

	Biological relationship	3billion ID (Family)
Family information	Daughter	EPA22-XXXX

SYMPTOMS / DETAILED SYMPTOMS

	Age of onset	Family with similar...
Delay development	Infancy	Mother
Ventricular septal defect	Infancy	Mother, Father
Low plasma cortisol	Infancy	Mother, Father
Calf muscle pseudohypertrophy	Infancy	Aunt, Uncle

	notes
Additional notes	<Patient symptoms additional information>

ADDITIONAL OPTION

	Gene
Gene	*SPOCK3, DEDD*

	Patient
Secondary finding	Yes
Reanalysis	Yes

SAMPLE INFORMATION

	Type	Collection date
Patient	Buccal Swab	2023-01-01

PHYSICIAN / RESEARCHER INFORMATION

	Name	Medical specialty	Phone number	Email
Physician / Researcher	<Physician name>	Pediatrics	<Phone number>	<Email address>

	Institution name	Address
Institution	<Institution name>	<Institution address>

	Name	Email	Name	Email
Sharer	<Sharer name>	<Sharer Email>	<Sharer name>	<Sharer Email>

Ordering Medical Professional Signature

I have discussed the Informed Consent for 3B-EXOME with the patient or their legal guardian. I have obtained any other consent from the patient and family members in accordance with my country/state and/or federal laws. I certify that the test ordered is medically necessary for the diagnosis or detection of a disease, illness, impairment, symptoms, syndrome, or disorder. The results of this test will be used in the patient's medical care decision and/or genetic counseling of the patient and family member(s). In addition to the above, I certify that I have the authority under applicable law to order this test as an ordering physician.

Date MM / DD / YYYY Signature _____

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