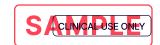


# REQUISITION FORM 3B-EXOME TRIO



# PATIENT INFORMATION

Patient	Unique ID	Sex	Date of Birth	Ethnicity	
	<unique id=""></unique>	Male	2021-10-10	East Asian	ETA23-XXXX
Father	Unique ID	Sex	Date of Birth	Ethnicity	
	<father id="" unique=""></father>	Male	1990-10-10	East Asian	ETA23-XXXXX
Mother	Unique ID	Sex	Date of Birth	Ethnicity	
	<father id="" unique=""></father>	Female	1990-10-10	East Asian	ETA23-XXXXX
Family information	Biological relationship	3billion ID (Family)			
	Daughter	EPA22-XXXX			

# **SYMPTOMS / DETAILED SYMPTOMS**

Delay development	Age of onset	Family with similar	Low plasma cortisol	Age of onset	Family with similar	
	Infancy	Mother		Infancy	Mother, Father	
Ventricular septal defect	Age of onset	Family with similar	Calf muscle	Age of onset	Family with similar	
	Infancy	Mother, Father	pseudohypertrophy	Infancy	Aunt, Uncle	
Additional notes	notes					
	<patient additional="" information="" symptoms=""></patient>					

# **ADDITIONAL OPTION**

Gene	Gene	Secondary finding	Patient	Father	Mother
	SPOCK3, DEDD		Yes	Yes	Yes
Reanalysis	Patient				
	Yes				

# **SAMPLE INFORMATION**

Patient	Type Collection date Father		Father	Туре	Collection date
	Buccal Swab	2023-01-01		Buccal Swab	2023-01-01
Mother	Туре	Collection date			
	Buccal Swab	2023-01-01			

# PHYSICIAN / RESEARCHER INFORMATION

Physician / Researcher	Name	Medical specialty	Phone number	Email	
	<physician name=""></physician>	Pediatrics	<phone number=""></phone>	<email address=""></email>	
Institution	Institution name	Address			
	<institution name=""></institution>	<institution address=""></institution>			
Sharer	Name	Email	Name	Email	
	<sharer name=""></sharer>	<sharer email=""></sharer>	<sharer name=""></sharer>	<sharer email=""></sharer>	



#### **REQUISITION FORM** 3B-EXOME TRIO



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	