REQUISITION FORM 3B-EXOME TRIO

SAMPLE CLINICAL USE ONLY

PATIENT INFORMATION

	Unique ID	Sex	Date of Birth	Ethnicity	
Patient	<Unique ID>	Male	2021-10-10	East Asian	ETA23-XXXX
Father	<Father Unique ID>	Male	1990-10-10	East Asian	ETA23-XXXXX
Mother	<Father Unique ID>	Female	1990-10-10	East Asian	ETA23-XXXXX

Family information	Biological relationship	3billion ID (Family)
	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

Additional notes	notes
	<Patient symptoms additional information>

ADDITIONAL OPTION

Gene	Gene
	SPOCK3, DEDD

Reanalysis	Patient
	Yes

Secondary finding	Patient	Father	Mother
	Yes	Yes	Yes

SAMPLE INFORMATION

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

PHYSICIAN / RESEARCHER INFORMATION

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

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

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

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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 _____