REQUISITION FORM **3B-GENOME** PROBAND

SAMPLE
CLINICAL USE ONLY

PATIENT INFORMATION

Patient	Unique ID	Sex	Date of Birth	Ethnicity	
	<Unique ID>	Male	1990-10-10	East Asian	GPA23-XXXX

Family information	Biological relationship	3billion ID (Family)
	Daughter	GPA22-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 pseudohypertrophy	Age of onset	Family with similar...
	Infancy	Mother, Father		Infancy	Aunt, Uncle

Additional notes	notes
	<Patient symptoms additional information>

ADDITIONAL OPTION

Gene	Gene	Secondary finding	Patient
	SPOCK3, DEDD		Yes

SAMPLE INFORMATION

Patient	Type	Collection date
	Whole Blood	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>

> ⊗ **Ordering Medical Professional Signature**
>
> I have discussed the Informed Consent for 3B-GENOME 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 _____