REQUISITION FORM 3B-VARIANT

SAMPLE CLINICAL USE ONLY

PATIENT INFORMATION

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

VPA23-XXXX

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

VARIANT INFORMATION

	Gene	Positon	Nomenclature
Primary Finding	EYS	6-66204776-TTCC-T	NM_001292009.1:c.525_527del(NP_001278938.1:p.Glu176del)
Secondary Finding	KMT2C	7-151927023-G-C	NM_001292009.1:c.525_527del(NP_001278938.1:p.Glu176del)

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-VARIANT 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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