



**GENETICS LABORATORY  
EXOME SLICE REQUISITION FORM**

PLEASE COMPLETE ALL FORMS AND  
SEND WITH PATIENT SAMPLE

Ship To: O'Donoghue Research Bldg  
1122 NE 13 Street, Suite 1400  
Oklahoma City, OK 73104  
Phone: 405-271-3589  
Fax: 405-271-7117  
After hours phone: 405-496-9514  
www.genetics.ouhsc.edu

REFERRING PHYSICIAN/FACILITY	PATIENT INFORMATION
Physician Name _____ NPI _____ Phone(____) _____ Fax(____) _____ Genetic Counselor _____ Phone(____) _____ Laboratory/Institution _____ Address _____ City _____ State _____ Zip _____ Phone_(____) _____ Fax (____) _____	Name (last,first,m.) _____ Parent Name (if patient is minor) _____ DOB _____ SSN _____ MRN _____ <b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Ambiguous <input type="checkbox"/> Other <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Ethnicity (check all that apply) <input type="checkbox"/> African-American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/NW European <input type="checkbox"/> E. Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Jewish-Ashkenazi <input type="checkbox"/> Jewish-Sephardic <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other _____ Address _____ City _____ State _____ Zip _____
SPECIMEN INFORMATION	
<input type="checkbox"/> <b>Peripheral Blood</b> 3-5 cc larged EDTA tube (purple top), mix well, keep at room temperature or cooler, do not freeze. <input type="checkbox"/> <b>Isolated DNA</b> qty 20ug Date Specimen Collected _____	
<p><b>If shipping materials via Fedex/UPS, packages can only be accepted Mon-Fri 9:00 AM to 5:00 PM. Our facilities are not accessible by delivery personnel on weekends or after hours. For courier service in Oklahoma City metro area call Rapid Transit 793-1122 for specimen pickup.</b></p>	
TEST OPTIONS	
<input type="checkbox"/> Exome SLICE Analysis Please provide a list of genes or the name of the specific disorder(s). _____ _____	
INDICATIONS FOR TESTING	
<input type="checkbox"/> Diagnostic <input type="checkbox"/> Family History of Disease/Disorder <input type="checkbox"/> Familial Variant	
<p><b>A COMPLETED PATIENT/PROBAND CLINICAL INFORMATION FORM AND CLINIC NOTES MUST ACCOMPANY THE SAMPLE.</b></p>	
PATIENT/GUARDIAN CONSENT– Please read the Informed Consent document before signing	
<p>I have read the Informed Consent document and I give OUHSC Genetics Lab my permission to perform the genetic testing listed above. I also give permission for [my/my child's] specimen and clinical information to be used in de-identified studies at OUHSC Genetics Lab to improve genetic testing and for publication, when appropriate. [My/my child's] name or other personal identifying information will not be used in or linked to the results of any studies and publications. I also give OUHSC Genetics Lab permission to inform me or [my/my child's] health care provider in the future about research opportunities, including treatments for the condition in [my/my child's] family.</p>	
<input type="checkbox"/> Check this box to opt-out of receiving secondary findings. _____ <input type="checkbox"/> Check this box to opt-out of research. _____	
_____ Patient/Guardian Signature	_____ Date
ADDITIONAL REPORT	GENETICS LABORATORY USE ONLY
Physician/Facility _____ Phone_(____) _____ Fax_(____) _____ Address _____	Laboratory Number _____ Date/Time/Location of Pick-Up or Delivery _____ Initials _____ Check-in _____ Previous Lab Number _____



**GENETICS LABORATORY**  
**WHOLE EXOME SLICE REQUISITION FORM**

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Name Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

**CONSENT AND AUTHORIZATION**

I understand that my health care provider has ordered exome sequencing for myself/my family member: \_\_\_\_\_

**INFORMED CONSENT**

**What are potential results from this test?**

There are three possible result outcomes:

- 1) **Positive Result:** A positive result indicates that a genetic change has been identified, and it explains the potential cause of [my/my child's] genetic condition or indicates that [I am/my child is] at increased risk to develop a disorder in the future. **It is possible to test positive for more than one genetic change.**
- 2) **Negative Result:** A negative result means that no disease-causing genetic change was identified in the test performed. **It does NOT guarantee that [I/my child] will be healthy or free from genetic disorders or medical conditions.** If [I/my child] test negative for a genetic change known to cause a specific condition in other members of the family, a diagnosis of the same genetic disorder in [me/my child] due to this specific change has been ruled out.
- 3) **Variant of Uncertain Significance (VUS):** A variant of uncertain significance indicates that a genetic change was detected, but it is currently unknown whether that change is associated with a genetic condition. **A VUS is not the same as a positive result** and does not specify whether [I am/my child] is at increased risk for a genetic condition. The variant may be a normal genetic change found in the human population, or it could be disease-causing. Further analysis may be warranted and include testing both parents (if not already tested) as well as other family members such as: siblings, grand parents, or aunts and uncles. Detailed medical records or additional information may be requested to re-classify this result.

**Additional Positive Results**

- 1) **Secondary Findings:** Secondary findings are genetic changes identified in genes that are unrelated to the individual's reported clinical features. **The American College of Medical Genetics and Genomics (ACMG) has recommended that secondary findings identified in a specific subset of medically actionable genes associated with various inherited disorders be reported for all probands undergoing whole exome sequencing.** Refer to the latest version of the *ACMG Recommendations for Reporting of Secondary Findings in Clinical Exome and Genome Sequencing* for a complete list of the genes and associated genetic disorders.
- 2) **Incidental Findings:** In rare instances, this test may reveal an unexpected, yet important genetic change that is not directly related to the reason for ordering this test. This test may tell me about the risk for another genetic condition [I am/my child] is not aware of, or it may indicate differences in the number or rearrangements of sex chromosomes. Information may be disclosed to the ordering health care provider if it will likely impact [your/ your child's] medical care.

**What will be reported**

- 1) For the proband: All known and/or expected disease-causing genetic changes identified in the coding exons of the genes correlating with the submitted phenotype, or included in the recommended gene list issued by ACMG.
- 2) For relatives: The presence or absence for any secondary findings reported for the proband will be provided for all relatives.

**Limitations and Risks**

- 1) Disease-causing genetic changes may be present in a portion of the gene not covered by this test and therefore are not reported. The absence of reportable secondary findings for any particular gene does not mean there are no disease-causing genetic changes.
- 2) Pathogenic variants that may be present in a relative, but are not present in the proband, will not be identified or reported.
- 3) Only changes in the genetic sequence will be reported in secondary findings. Larger deletions/duplications, abnormal methylations, triplet repeats and other expansions, or other variants not routinely identified by whole exome sequencing will not be reported.
- 4) This test has the potential to identify non-paternity and consanguinity (relatedness) between the proband's parents. It may be necessary to report these results to the health care provider who ordered the test if it will affect medical management of the proband.
- 5) Inaccurate results may be reported due to mislabeled samples, inaccurate reporting of clinical/medical information, rare technical errors, or unusual circumstances such as bone marrow transplantation, or the presence of mosaicism (change not present in every cell).

**Interpretation**

- 1) Results will be interpreted with available information in the medical literature, research databases, and scientific databases. Due to the change in medical/scientific knowledge and published studies, new information that becomes available may replace or build upon the information utilized in the interpretation of [my/my child's] results.
- 2) Providers can contact the laboratory at any time to discuss the classification or re-classification of an identified genetic change.
- 3) [My/my child's] health care providers and I may monitor publicly available resources used by the medical community, such as ClinVar ([www.clinvar.com](http://www.clinvar.com)), to find updated information about the interpretation of [my/my child's] genetic change(s).
- 4) Results will be released in a single report in the proband's name. Additional reports will NOT be released in the proband's family members' names if a trio is submitted.
- 5) Occasionally, an additional sample may be needed if the initial specimen is not adequate for analysis.

**Patient Confidentiality and Genetic Counseling**

- 1) It is strongly recommended that [I/my child] receive genetic counseling before and after having this test. I can find a genetic counselor in my area at [www.nsgc.org](http://www.nsgc.org).
- 2) Further testing or consultations may be necessary based on results.
- 3) To maintain confidentiality, the test results will only be released to the referring health care provider, the ordering laboratory, me, other health care providers involved in [my/my child's] diagnosis and treatment, or to others as entitled by law.
- 4) The United States Federal Government has enacted several laws that prohibit discrimination based on genetic test results by health insurance companies and employers. In addition, these laws prohibit unauthorized disclosure of this information. For more information, I understand I can visit [www.genome.gov/10002077](http://www.genome.gov/10002077).



Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_ DOB: \_\_\_\_\_

<p><b>Primary Indications for Testing</b></p> <p><input type="checkbox"/> Multiple Congenital Anomalies  <input type="checkbox"/> Developmental Delays  <input type="checkbox"/> Neurological/Muscular Disorder</p> <p><b>Previous Testing</b></p> <p><input type="checkbox"/> Karyotype/FISH  <input type="checkbox"/> CMA  <input type="checkbox"/> Newborn Screen Result  <input type="checkbox"/> Other Results _____</p> <p><b>Family History (provide pedigree)</b></p> <p><input type="checkbox"/> Consanguinity  <input type="checkbox"/> Family History of Genetic Disease/Disorder</p>		<p><b>Development &amp; Cognition</b></p> <p><input type="checkbox"/> Autism Spectrum  <input type="checkbox"/> Fine Motor Delays  <input type="checkbox"/> Global Delay  <input type="checkbox"/> Gross Motor Delays  <input type="checkbox"/> Intellectual Delays  <input type="checkbox"/> Mild  <input type="checkbox"/> Moderate  <input type="checkbox"/> Severe  <input type="checkbox"/> Learning Delays  <input type="checkbox"/> Speech Delay</p>	
<p><b>Perinatal History</b></p> <p><input type="checkbox"/> IUGR / SGA</p> <p><b>Growth</b></p> <p><input type="checkbox"/> Failure to thrive  <input type="checkbox"/> Macrocephaly  <input type="checkbox"/> Microcephaly  <input type="checkbox"/> Overgrowth/Tall  <input type="checkbox"/> Short stature  <input type="checkbox"/> Other: _____</p> <p><b>Craniofacial Anomalies</b></p> <p><input type="checkbox"/> Cleft Lip  <input type="checkbox"/> Cleft Palate  <input type="checkbox"/> Craniosynostosis  <input type="checkbox"/> Dysmorphic Facies  <input type="checkbox"/> Ear Malformation  <input type="checkbox"/> Other: _____</p> <p><b>Ear / Hearing Loss (HL)</b></p> <p><input type="checkbox"/> Conductive HL  <input type="checkbox"/> Microtia  <input type="checkbox"/> Sensorineural HL  <input type="checkbox"/> Other: _____</p> <p><b>Eye Anomalies</b></p> <p><input type="checkbox"/> Aniridia  <input type="checkbox"/> Congenital Cataract  <input type="checkbox"/> Cortical Blindness/CVI  <input type="checkbox"/> Coloboma  <input type="checkbox"/> Glaucoma  <input type="checkbox"/> Optic Nerve Abnormality  <input type="checkbox"/> Ptosis  <input type="checkbox"/> Retinitis Pigmentosa  <input type="checkbox"/> Other: _____</p> <p><b>Pulmonary</b></p> <p><input type="checkbox"/> Diaphragmatic Hernia  <input type="checkbox"/> TE Fistula  <input type="checkbox"/> Other: _____</p>	<p><b>Cardiac</b></p> <p><input type="checkbox"/> Arrhythmia  <input type="checkbox"/> ASD  <input type="checkbox"/> Cardiomyopathy  <input type="checkbox"/> Coarctation of aorta  <input type="checkbox"/> Dextrocardia  <input type="checkbox"/> Tetralogy of fallot  <input type="checkbox"/> Ventriculomegaly  <input type="checkbox"/> VSD  <input type="checkbox"/> Other: _____</p> <p><b>GI</b></p> <p><input type="checkbox"/> Anal Atresia  <input type="checkbox"/> Chronic Obstruction  <input type="checkbox"/> Dysphagia  <input type="checkbox"/> Esophageal Atresia  <input type="checkbox"/> Gastroschisis  <input type="checkbox"/> Hirschsprung Disease  <input type="checkbox"/> Liver Disease  <input type="checkbox"/> Omphalocele  <input type="checkbox"/> Polysplenia  <input type="checkbox"/> Situs Inversus  <input type="checkbox"/> Other: _____</p> <p><b>Genitourinary</b></p> <p><input type="checkbox"/> Ambiguous Genitals  <input type="checkbox"/> Cryptorchidism  <input type="checkbox"/> Hydronephrosis  <input type="checkbox"/> Hypospadias  <input type="checkbox"/> Kidney Malformation  <input type="checkbox"/> Renal Agenesis  <input type="checkbox"/> Renal Tubulopathy  <input type="checkbox"/> Other: _____</p>	<p><b>Skeletal</b></p> <p><input type="checkbox"/> Arthrogyrosis  <input type="checkbox"/> Club Foot/Feet  <input type="checkbox"/> Contractures  <input type="checkbox"/> Joint Hypermobility  <input type="checkbox"/> Kyphosis  <input type="checkbox"/> Limb Anomaly  <input type="checkbox"/> Osteopenia  <input type="checkbox"/> Pes Planus  <input type="checkbox"/> Polydactyly  <input type="checkbox"/> Scoliosis  <input type="checkbox"/> Skeletal Dysplasia  <input type="checkbox"/> Syndactyly  <input type="checkbox"/> Vertebral anomaly  <input type="checkbox"/> Other: _____</p> <p><b>Endocrine</b></p> <p><input type="checkbox"/> Diabetes Insipidus  <input type="checkbox"/> Diabetes Mellitus  <input type="checkbox"/> Hyperthyroidism  <input type="checkbox"/> Hypothyroidism  <input type="checkbox"/> Hyperparathyroidism  <input type="checkbox"/> Hypoparathyroidism</p> <p><b>Hematologic/Immuno</b></p> <p><input type="checkbox"/> Anemia  <input type="checkbox"/> Immunodeficient  <input type="checkbox"/> Neutropenia  <input type="checkbox"/> Pancytopenia  <input type="checkbox"/> Thrombocytopenia  <input type="checkbox"/> Other: _____</p>	<p><b>Neurological &amp; Muscular</b></p> <p><input type="checkbox"/> Ataxia  <input type="checkbox"/> Brain Anomaly  <input type="checkbox"/> Cerebellar anomaly  <input type="checkbox"/> Chorea/Dystonia  <input type="checkbox"/> Encephalopathy  <input type="checkbox"/> Holoprosencephaly  <input type="checkbox"/> Hydrocephalus  <input type="checkbox"/> Hypertonia  <input type="checkbox"/> Hypotonia  <input type="checkbox"/> Lissencephaly  <input type="checkbox"/> Leukodystrophy  <input type="checkbox"/> Muscle Weakness/Atrophy  <input type="checkbox"/> Peripheral Neuropathy  <input type="checkbox"/> Vermis Hypoplasia  <input type="checkbox"/> Other: _____</p> <p><b>Cancer/Tumors</b></p> <p><input type="checkbox"/> Tumor (describe) _____          _____          Age of Onset _____</p> <p><b>Skin, Hair &amp; Nails</b></p> <p><input type="checkbox"/> Abnormal Hair  <input type="checkbox"/> Abnormal Nails  <input type="checkbox"/> Hyperpigmentation (describe) _____  <input type="checkbox"/> Hypopigmentation (describe) _____  <input type="checkbox"/> Lipoma  <input type="checkbox"/> Other: _____</p> <p><b>Metabolic Abnormalities</b></p> <p><input type="checkbox"/> Hyperammonemia  <input type="checkbox"/> Ketosis  <input type="checkbox"/> Lactic Acidosis  <input type="checkbox"/> Metabolic Acidemia  <input type="checkbox"/> Other: _____</p>



Patient Name LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_

**YOU MUST CHOOSE ONE OF THE THREE BILLING OPTIONS LISTED BELOW.  
PLEASE FORWARD ALL BILLING QUESTIONS TO DANIELLE OTIS AT DOTIS@OUHSC.EDU OR CALL 405-271-3589 OPT 4  
AT THIS TIME WE DO NOT ACCEPT OUT-OF-STATE MEDICAID**

**PAYMENT OPTION 1-INSTITUTION**

INSTITUTION NAME \_\_\_\_\_  
BILLING ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_ CONTACT NAME \_\_\_\_\_  
PHONE NUMBER \_\_\_\_\_ FAX NUMBER \_\_\_\_\_ CONTACT EMAIL ADDRESS \_\_\_\_\_

**PAYMENT OPTION 2-SELF PAY (PAYMENT MUST BE SENT WITH SAMPLE)**

**CREDIT CARD** (CIRCLE ONE) AMEX DISCOVER VISA MASTERCARD AMOUNT TO CHARGE \_\_\_\_\_  
VALID CARD # \_\_\_\_\_ EXP DATE \_\_\_\_\_  
CVV CODE \_\_\_\_\_ CARDHOLDER PRINTED NAME \_\_\_\_\_  
BILLING ADDRESS \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_  
CARDHOLDER SIGNATURE \_\_\_\_\_  
 **CHECK** # \_\_\_\_\_ AMOUNT ENCLOSED \_\_\_\_\_

**PAYMENT OPTION 3-INSURANCE PROVIDE A LEGIBLE COPY OF THE FRONT & BACK OF INSURANCE CARD  
PLEASE NOTE: OUR FACILITY WILL CONFIRM COVERAGE AND VERIFY WHETHER OR NOT THE TEST(S) ORDERED ARE COVERED BY YOUR PLAN.  
OUR OFFICE CAN ALSO OBTAIN PRE-AUTHORIZATION FROM THE INSURANCE PLAN.**

**PRIMARY** INSURANCE POLICYHOLDER NAME \_\_\_\_\_ POLICYHOLDER DOB \_\_\_\_\_  
PRIMARY POLICYHOLDER SS# \_\_\_\_\_ GENDER: M F EMPLOYER \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_ POLICY # \_\_\_\_\_  
GROUP # \_\_\_\_\_ INSURANCE CO. NAME \_\_\_\_\_  
PHONE \_\_\_\_\_ CLAIMS ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_ INSURANCE AUTH # \_\_\_\_\_

**SECONDARY** INSURANCE POLICYHOLDER NAME \_\_\_\_\_ POLICYHOLDER DOB \_\_\_\_\_  
SECONDARY POLICYHOLDER SS# \_\_\_\_\_ GENDER: M F EMPLOYER \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_ POLICY # \_\_\_\_\_  
GROUP # \_\_\_\_\_ INSURANCE CO. NAME \_\_\_\_\_  
PHONE \_\_\_\_\_ CLAIMS ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_ INSURANCE AUTH # \_\_\_\_\_

I CONSENT TO HAVE THE TEST(S) LISTED ON THE PREVIOUS PAGE PERFORMED. I AUTHORIZE THE UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY TO FURNISH ANY MEDICAL INFORMATION REQUESTED ON MYSELF, OR MY COVERED DEPENDENTS. IN CONSIDERATION OF SERVICES RENDERED, I TRANSFER AND ASSIGN ANY BENEFITS OF INSURANCE TO UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY. I UNDERSTAND I AM RESPONSIBLE FOR ANY CO-PAY, DEDUCTIBLES, OR NON-AUTHORIZED SERVICES AND REMAINING BALANCES AFTER INSURANCE REIMBURSEMENT. I UNDERSTAND I AM FULLY RESPONSIBLE FOR PAYMENT OF MY ACCOUNT IF THE UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY IS NOT A PARTICIPANT WITH MY HEALTH PLAN OR MY HEALTH PLAN DOES NOT FULLY REIMBURSE MY MEDICAL SERVICES DUE TO LACK OF AUTHORIZATION OR MEDICAL NECESSITY.

PRINTED NAME \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_