Test Requisition Form

neurocode

2405 Wesbrook Mall, room 5524
Vancouver BC
V6T 1Z3
www.neurocode.com

Test Selection

☐ Targeted Whole Exome Sequencing - Proband Only
☐ Targeted Whole Exome Sequencing - Trio
☐ Confirmatory Sanger sequencing validation
☐ Re-analysis (at least one year after initial analysis)

This specimen is (specify):
☐ Proband (i.e. affected child)
☐ Proband's Father ☐ Proband's Mother

Specimen Information

Sample type
☐ Whole Blood (in EDTA, 2-5 ml in lavender top tube)
☐ Oral Rinse (At least 30 mL of Scope oral rinse in 50ml falcon tube)
☐ DNA, source _____

Collection Date (YYYY-MM-DD):

Label each tube with the subject's initials, PHN, and specimen collection date. Sample label must match requisition form.

Patient has had a blood transfusion ☐ No ☐ Yes
Date of last transfusion (YYYY-MM-DD) _____
Specimens are not accepted for patients who have had:
- allogeneic bone marrow transplants;
- blood transfusion <2-4 weeks prior to specimen collection

DNA must be extracted in a suitably certified laboratory

Ordering Physician Information

Physician Name:

MSP Number (in BC):

Street Address:

City: Province:

Postal Code:

Institution:

Phone:
Fax:
E-mail address:

Additional Report Recipient 1

Physician/GC * Name:
*Genetic Counselor

MSP Number (in BC):

Phone:
Fax:
E-mail address:

Additional Report Recipient 2

Physician/GC * Name:
*Genetic Counselor
MSP Number (in BC):

Phone:
Fax:
E-mail address:

Requesting Laboratory (for confirmatory Sanger sequencing validation only)

Facility Name:

Street Address:

City: Province:

Postal Code:

Telephone: Fax:

Contact Name:

HGNC gene symbol:

Genomic position (hg19):

Ref/Alt allele:

HGVS* DNA change:

HGVS* protein change:

*http://varnomen.hgvs.org/recommendations/general/

Neurocode Labs Use Only

Received Date:

Received Person:

(Patient information Sticker)

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Payment Information (required)

Name: Street Address: City: Province/State: Postal Code: Country: Phone:	Contact Neurocode Labs, Inc. for pricing. □ Cheque or Bank Draft (make payable to Neurocode Labs, Inc.) in Canadian funds. □ Bank Transfer – please contact Neurocode Labs, Inc. for account information: accounting@neurocode.com

Patient Information

Last Name:	First Name and Initials:	
DOB (YYYY-MM-DD):	Sex (check one): ☐ female ☐ male ☐ unknown	PHN:
Family History (including information about parental consanguinity):		
Ethnicity (check all that apply): ☐ African ☐ Ashkenazi ☐ Asian ☐ Caucasian ☐ First Nations ☐ Hispanic ☐ Other (specify _____)		

Biological Parent Data - Mother

Last Name:	First Name and Initials:
DOB (YYYY-MM-DD):	
Affected: ☐ Yes ☐ No ☐ No, but a family member is	
Sample: ☐ Not Available ☐ Sent Separately ☐Also included	

Biological Parent Data - Father

Last Name:	First Name and Initials:
DOB (YYYY-MM-DD):	
Affected: ☐ Yes ☐ No ☐ No, but a family member is	
Sample: ☐ Not Available ☐ Sent Separately ☐Also included	

Clinical Diagnosis

Clinical diagnosis:	Describe the most relevant clinical findings supporting the diagnosis (attach possible supportive material):

Detailed clinical information is crucial for accurate interpretation of results.

Previous Clinical Investigations

Karyotype:	☐ Not applicable	☐ Normal	☐ Abnormal, specify:
Microarray:	☐ Not applicable	☐ Normal	☐ Abnormal, specify:
Metabolic testing:	☐ Not applicable	☐ Normal	☐ Abnormal, specify:
Single gene / Multi-gene panel:	☐ Not applicable	I ☐ Normal	☐ Abnormal, specify:
Other tests:			

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Clinical Information

Please check all that apply.

PERINATAL HISTORY
□ Cystic Hygroma
□ Hydrops Fetalis
□ Increased Nuchal Translucency (NT)
□ Intrauterine Growth Restriction (IUGR)
□ Oligohydramnios
□ Polyhydramnios
□ Prematurity
□ Other _____

GROWTH
□ Failure to Thrive
□ Growth retardation/short stature
□ Overgrowth
□ Other

NERODEVELOPMENTAL
□ ADHD
□ Autism
□ Developmental Delay
□ Intellectual Disability, IQ:_____
□ Encephalopathy
□ Fine Motor Delay
□ Gross Motor Delay
□ Seizure (type: _____)
□ Psychiatric symptoms
□ Learning Disability
□ Obsessive-Compulsive Disorder
□ Speech Delay
□ Other _____

BRAIN MALFORMATIONS/ABNORMAL IMAGING
□ Abnormalities of basal ganglia
□ Agenesis of the corpus callosum
□ Brain atrophy
□ Cortical dysplasia
□ Hemimegalencephaly
□ Heterotopia
□ Holoprosencephaly
□ Hydrocephalus
□ Lissencephaly
□ Microcephaly
□ Macrocephaly
□ Periventricular leukomalacia
□ Other: _____

NEUROMUSCULAR
□ Ataxia
□ Chorea
□ Hypotonia
□ Hypertonia
□ Spasticity
□ Dystonia
□ Muscle Weakness / Atrophy
□ Exercise Intolerance
□ Other_____

CRANIOFACIAL (INCLUDING HEARING & VISION)
□ Abnormal Eye Movement
□ Abnormal Hearing
□ Abnormal Vision
□ Blindness
□ Cataracts
□ Cleft Lip/ Palate
□ Coloboma (of eye)
□ Chronic Progressive External Ophthalmoplegia
□ Dysmorphic Features (describe)
_____
_____
_____
□ Ear Malformation
□ Optic Atrophy
□ Ptosis
□ Retinitis Pigmentosa
□ Other _____

SKELETAL/LIMB ABNORMALITIES
□ Club Foot / Feet
□ Contractures
□ Diaphragmatic Hernia
□ Joint Hypermobility
□ Kyphosis
□ Limb Anomaly
□ Pes Planus
□ Polydactyly
□ Pterygium
□ Scoliosis
□ Syndactyly
□ Vertebral Anomaly

SKIN, HAIR, AND NAILS
□ Abnormal hair_____
□ Abnormal nails:_____
□ Abnormal pigmentation:_____
□ Abnormal connective tissue: _____
□ Blistering
□ Ichthyosis
□ Skin tumors/Malignancies
□ Other: _____

HEMATOLOGIC AND IMMUNOLOGIC
□ Anemia
□ Coagulation disorder
□ Immunodeficiency
□ Neutropenia
□ Pancytopenia
□ Thrombocytopenia
□ Other_____

METABOLIC
□ Abnormal CPK
□ Elevated alanine
□ Elevated puyruvate
□ Ketosis
□ Lactic Acidosis
□ Organic Aciduria
□ Other _____

ENDOCRINE
□ Diabetes Mellitus (□ Type I; □ Type II)
□ Hyperparathyroidism
□ Hyperthyroidism
□ Hypoparathyroidism
□ Hypothyroidism
□ Hypoglycemia
□ Pheochromocytoma/paraganglioma
□ Other _____

GASTROINTESTINAL
□ Chronic Constipation
□ Chronic Diarrhea
□ Chronic Intestinal Pseudoobstruction
□ Elevated transaminases
□ Gastroesophageal Reflux
□ Gastroschisis/Omphalocele
□ Hepatic failure
□ Hirschsprung Disease
□ Pyloric Stenosis
□ Recurrent Vomiting
□ Tracheoesophageal Fistula
□ Other _____

GENITOURINARY
□ Ambiguous Genitalia
□ Cryptochidism
□ Hydronephrosis
□ Hypospadias
□ Kidney Malformation
□ Renal Agenesis or Dysgenesis
□ Renal Tubulopathy
□ Other _____

CARDIOVASCULAR
□ Arrhythmia
□ ASD
□ Cardiomyopathy
□ Coarctation of Aorta
□ Tetralogy of Fallot
□ Hypoplastic left heart
□ Stroke
□ VSD
□ Other _____

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Physician's Statement and Signature

*This test is **medically necessary** for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results could direct medical management and treatment decisions. By my signature below, I indicate that I am the referring physician and/or authorized health care provider. I have explained the purpose, possible results and limitations of the test described above. The patient and/or patient's legal guardian has been given the opportunity to ask questions and/or seek genetic counseling. The patient, or the patient's legal guardian, has given informed consent for the test described above to be performed.*

Ordering Physician's Signature:	Date (YYYY-MM-DD):

Patient Consent to Receipt of Secondary (incidental) Findings

According to the current CCMG position statement (PMID: 25951830), Neurocode Labs does not intentionally search for variants unrelated to the patient's primary indication. However, it is possible that during the analysis, variants associated with conditions other than those relevant to patient's presentation are incidentally identified. Such findings are termed as secondary findings or incidental findings. Incidental findings are only included if variants are interpreted as pathogenic or likely pathogenic and if the patient consented to the return of these secondary findings.

I, the patient, or the patient's legal guardian, have had the implications and limitations of the requested genetic test, including the possibility of secondary findings, explained by the referring physician or health care provider and give informed consent to have the test, described above, performed.

☐ *Check this box if you wish to receive CCMG secondary findings.*

Patient (Guardian) Signature:	Date (YYYY-MM-DD):

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Requisition Instructions

Instructions for the proper completion of the test requisition can be found on our website at http://www.neurocode.com/tests.html, under the "Test Requisition Form" section.

Shipping Instructions

Samples should be shipped according to IATA, ICAO and TDG regulations. ***All samples should be transported at room temperature and shipped on the same day or as soon as possible after sample collection/processing.*** If possible, samples should be collected Monday to Wednesday to ensure delivery to our facility before the weekend.

Sample handling/storage information prior to shipping:

Blood - samples can be stored at 4˚C (for no longer than 3-4 days) or at -20˚C for longer periods.
Oral rinse – samples should be stored at 4˚C until ready for transport.
DNA - should be stored at -20˚C until ready for transport.

Packages should include:
1) labelled sample(s) (with subject's initials, PHN and sample collection date)
2) the corresponding completed test requisition. **Please note**: samples that do not meet the requirements listed at http://www.neurocode.com/samples.html *will be rejected*. Incomplete test requisitions will result in testing delays, or possible sample rejection.

Ship samples to the following address:

Neurocode Labs, Inc.
Attn: Ilaria Guella
Room 5524, 2405 Wesbrook Mall
Vancouver, BC
Canada V6T 1Z3

If you have any questions regarding sample collection/processing and shipping, please do not hesitate to contact us at info@neurocode.com.