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

Test Selection

☐ Whole Exome Sequencing for Neurological Disorder
- ☐ Proband Only
- ☐ Trio – This specimen is (specify): ☐ Proband (i.e., affected child) ☐ Proband's Father ☐ Proband's Mother

Note: **both biological parents must be available for trio testing.** Each individual must have their data recorded in the "Biological Parent Data" section and have a sample sent for testing along with their own test requisition.

☐ Confirmatory Sanger sequencing validation

Specimen Information

Sample type	Collection Date (YYYY-MM-DD):
☐ Whole Blood (in EDTA, 3-5 ml in lavender top tube) ☐ Oral Rinse (in 50ml falcon tube) ☐ DNA, source _____	

Ordering Physician Information	Additional Report Recipient 1
Physician Name:	Physician/GC * Name: *Genetic Counselor
MSP Number (in BC):	MSP Number (in BC):
Street Address:	Phone: Fax: E-mail address:
City: Province:	
Postal Code:	**Additional Report Recipient 2**
Institution:	Physician/GC * Name: *Genetic Counselor MSP Number (in BC):
Phone: Fax: E-mail address:	Phone: Fax: E-mail address:

Requesting Laboratory

Facility Name:	HGNC gene symbol:
Street Address:	HGVS protein change:
City: Province:	Transcript ID:
Postal Code:	
Telephone: Fax: Contact Name:	

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Patient Information	Clinical Diagnosis
Name (Last, First, Initials):	■ Epilepsy/Seizure Disorder
DOB (YYYY-MM-DD):	Subtype (check all that may apply): ☐ EIEE ☐ GEFS+ ☐ Febrile Seizures ☐ Dravet Syndrome ☐ clonic ☐ tonic ☐ absence ☐ Other Seizure Disorder_____
PHN:	
Sex (check one): ☐ female ☐ male ☐ unknown/ambiguous	
Ethnicity (check all that apply): ☐ African ☐ First Nations ☐ Ashkenazi ☐ Hispanic ☐ Asian ☐ Other (specify below) ☐ Caucasian _____	

Biological Parent Data - Mother	Biological Parent Data - Father
Name (Last, First, Initials):	Name (Last, First, Initials):
DOB (YYYY-MM-DD):	DOB (YYYY-MM-DD):
Affected: ☐ Yes ☐ No ☐ No, but a family member is	Affected: ☐ Yes ☐ No ☐ No, but a family member is
Sample: ☐ Not Available (proband testing only) ☐ Sent Separately (trio testing)	Sample: ☐ Not Available (proband testing only) ☐ Sent Separately (trio testing)

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 will determine my patient's medical management and treatment decisions. By my signature below, I indicate that I am the referring physician or authorized health care provider. I have explained the purpose of the test described above. The patient has been given the opportunity to ask questions and/or seek genetic counseling. The patient has voluntarily decided to have the test performed by Neurocode Labs, Inc.*

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

Physician's Consent to Receipt of Secondary Findings

In addition to possible results regarding the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder, this test may detect genetic changes which are known to be associated with unrelated, but potentially medically actionable diseases, illnesses, syndromes or disorders. Neurocode Labs, Inc. uses the list of genes published, maintained and periodically updated by the American College of Medical Genetics. A copy of the publication detailing the list of genes and associated phenotypes is available at http://www.neurocode.com/ACMG_SFv2.pdf. (continued)

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By signing below, the physician grants permission to Neurocode Labs, Inc., to validate and return any detected changes in the genes described in the list above. The patient has been advised of the potential for this unrelated information to be discovered and returned to their physician, who will make the determination as to whether or not to communicate this information back to the patient. The patient has been given the opportunity to ask questions and/or seek genetic counseling. The results will determine my patient's medical management and treatment decisions. By my signature below, I indicate that I am the referring physician or authorized health care provider. I have explained the purpose of the test described above. The patient has voluntarily decided to have the test performed by Neurocode Labs, Inc.

Ordering Physician's 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 name and 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: Alexander Young
Room 5524, 2405 Wesbrook Mall
Vancouver, BC
Canada V6T 1Z3
Telephone: (604) 827-1980

If you have any questions regarding sample collection/processing and shipping, please do not hesitate to contact us by telephone at (604) 827-1980.