REQUISITION FORM

Unique ID _____ Date of birth YYYY / MM / DD

3B-GENOME

Patient Profile (For Proband)

You must fill in all the required fields (*).

Patient Information

Sex* ○ Male ○ Female

Age of onset* ○ Antenatal ○ Neonatal ○ Infancy ○ Childhood ○ Adolescent ○ Adult ○ Elderly

Ethinicity* ○ African/African-American ○ Amish ○ Ashkenazi Jewish ○ East Asian ○ Latino/Admixed American ○ Finnish ○ Non-Finnish European ○ South Asian ○ Other: _____

Family history ○ Father ○ Mother ○ Brother ○ Sister ○ Father's Father ○ Father's Mother ○ Mother's Father ○ Mother's Mother ○ Other: _____

Sample Information

Type of sample* ○ Whole Blood ○ Dried Blood Spot Card ○ Extracted gDNA: Source of DNA

Collection date* YYYY / MM / DD

Product Information

Secondary finding* ○ Yes ○ No

Related previous order 3billion Sample ID

Relationship with the patient e.g. Sibling

Ordering Medical Professional & Institution Information

You must fill in all the required fields (*).

Ordering Medical Professional Information

Name* _____

Medical specialty* _____

Phone number* _____

Email* _____ @ _____

Institution Information

Institution name _____

Department _____

Country _____

City _____

Address _____

ZIP/Postal code _____

Ordering Medical Professional Signature

I have discussed the Informed Consent form 3B-GENOME with the patient or their legal guardian.
I agree to allow name of proxy doctor/institution to order 3billion's service on behalf of myself.
I also confirm that I have received consent from the patient and/or family members in accordance with local laws to obtain all relevant data including the patient's information and clinical reports provided by 3billion. I certify that the test ordered is medically necessary for the diagnosis or detection of a disease, illness, impairment, symptoms, syndrome, or disorders. The result of this test will be used in the patient's medical care decision and/or genetic counselling 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 YYYY / MM / DD

Signature _____

For Proband

Unique ID _____ Date of birth YYYY / MM / DD

ⓘ Please select all that apply

Pre/Perinatal History

- ☐ Cystic hygroma
- ☐ Diaphragmatic hernia
- ☐ Encephalocele
- ☐ Growth delay
- ☐ Increased nuchal translucency
- ☐ Intrauterine Growth Retardation
- ☐ Nonimmune hydrops fetalis
- ☐ Oligohydramnios
- ☐ Omphalocele
- ☐ Polyhydramnios
- ☐ Prematurity GA: _____
- ☐ Prolonged neonatal jaundice
- ☐ Others: _____

Structural Brain Abnormalities

- ☐ Abnormal myelination
- ☐ Abnormality of basal ganglia
- ☐ Abnormality of brainstem
- ☐ Abnormality of periventricular white matter
- ☐ Abnormality of the corpus callosum
- ☐ Aplasia/hypoplasia of cerebellar vermis
- ☐ Aplasia/hypoplasia of cerebellum
- ☐ Arnold Chiari malformation
- ☐ Cerebellar atrophy
- ☐ Heterotopia (Periventricular nodular heterotopia)
- ☐ Holoprosencephaly
- ☐ Hydrocephalus
- ☐ Leukodystrophy
- ☐ Lissencephaly
- ☐ Pachygyria
- ☐ Polymicrogyria
- ☐ Ventriculomegaly
- ☐ Others: _____

Developmental / Behavioral Findings

- ☐ Absent speech
- ☐ Aggressive behavior
- ☐ Anxiety
- ☐ Autistic Behavior
- ☐ Cognitive impairment
- ☐ Delayed speech & language development
- ☐ Developmental regression
- ☐ Dysarthria
- ☐ Gait disturbance
- ☐ Global developmental delay
- ☐ Hyperactivity
- ☐ Incoordination
- ☐ Intellectual disability
- ☐ Learning disability
- ☐ Memory impairment
- ☐ Sleep disturbance
- ☐ Stereotypy
- ☐ Others: _____

Neurological Findings

- ☐ Abnormality of nervous system
- ☐ Ataxia
- ☐ Cerebral palsy
- ☐ Chorea
- ☐ Cortical Visual Impairment
- ☐ Dementia
- ☐ Dysarthria
- ☐ Dyskinesia
- ☐ Dysphasia
- ☐ Dystonia
- ☐ Encephalopathy
- ☐ Headaches
- ☐ Hemiplegia
- ☐ Infantile Spasms
- ☐ Migraines
- ☐ Myoclonus
- ☐ Parkinsonism
- ☐ Peripheral neuropathy
- ☐ Seizures
- ☐ Sensory neuropathy
- ☐ Spasticity
- ☐ Syncope
- ☐ Tremors
- ☐ Vertigo
- ☐ Others: _____

Craniofacial/Dysmorphism

- ☐ Abnormal facial shape (Dysmorphic features)
- ☐ Specify: _____
- ☐ Brachycephaly
- ☐ Cleft lip and/or palate
- ☐ Coarse facial features
- ☐ Craniosynos tosis
- ☐ Macrocephaly
- ☐ Microcephaly
- ☐ Short neck
- ☐ Synophrys
- ☐ Others: _____

Eye Defects / Vision

- ☐ Abnormality of Vision
- ☐ Anophthalmia
- ☐ Cataracts
- ☐ Coloboma
- ☐ Corneal opacity
- ☐ Ectopia lentis
- ☐ External ophthalmoplegia
- ☐ Microphthalmia
- ☐ Myopia
- ☐ Nystagmus
- ☐ Optic atrophy
- ☐ Optic neuropathy
- ☐ Ptosis
- ☐ Retinal detachment
- ☐ Retinitis pigmentosa
- ☐ Strabismus
- ☐ Others: _____

Hearing Impairment

- ☐ Abnormal Newborn Screen: _____
- ☐ Conductive hearing impairment
- ☐ Sensorineural hearing impairment
- ☐ Others: _____

Endocrine Findings

- ☐ Delayed puberty
- ☐ Diabetes Insipidus
- ☐ Diabetes Mellitus
- ☐ Hyperthyroidism
- ☐ Hypophosphatemia
- ☐ Hypothyroidism
- ☐ Maturity-onset diabetes of the young
- ☐ Rickets
- ☐ Others: _____

Respiratory Findings

- ☐ Asthma
- ☐ Bronchiectasis
- ☐ Hyperventilation
- ☐ Hypoventilation
- ☐ Pneumothorax
- ☐ Pulmonary fibrosis
- ☐ Respiratory insufficiency
- ☐ Others: _____

Hematologic or Immunologic Findings

- ☐ Allergic rhinitis
- ☐ Anemia
- ☐ Immunodeficiency
- ☐ Neutropenia
- ☐ Pancytopenia
- ☐ Recurrent infections
- ☐ Thrombocytopenia
- ☐ Others: _____

Skin/Hair Findings

- ☐ Abnormal blistering of the skin
- ☐ Abnormality of nail
- ☐ Alopecia
- ☐ Anhidrosis
- ☐ Café-Au-Lait Macules
- ☐ Coarse hair
- ☐ Cutis Laxa
- ☐ Eczema
- ☐ Hemangiomas
- ☐ Hyperextensible skin
- ☐ Hyperpigmentation of the skin
- ☐ Hypohidrosis
- ☐ Hypopigmentation of the skin
- ☐ Ichthyosis
- ☐ Skin rash
- ☐ Sparse hair
- ☐ Telangiectasia
- ☐ Vascular skin abnormality
- ☐ Velvety skin
- ☐ Others: _____

For Proband

Unique ID _____ Date of birth YYYY / MM / DD

ℹ Please select all that apply

Cardiac Findings

- ☐ Abnormal heart morphology
- ☐ Amyloidosis
- ☐ Aortic root dilation
- ☐ Arrhythmia
- ☐ Atrial septal defect
- ☐ Bicuspid aortic valve
- ☐ Bradycardia
- ☐ Coarctation of aorta
- ☐ Dilated cardiomyopathy
- ☐ Heterotaxy
- ☐ Hypertension
- ☐ Hypertrophic cardiomyopathy
- ☐ Mitral valve prolapse
- ☐ Noncompaction cardiomyopathy
- ☐ Patent ductus arteriosis
- ☐ Patent foramen ovale
- ☐ Prolonged QTc interval
- ☐ Sudden death
- ☐ Tetralogy of Fallot
- ☐ Ventricular septal defect
- ☐ Ventricular tachycardia
- ☐ Others: _____

Gastrointestinal Findings

- ☐ Constipation
- ☐ Diarrhea
- ☐ Duodenal stenosis/atresia
- ☐ Failure to thrive
- ☐ Feeding difficulties
- ☐ Gastroesophageal reflux
- ☐ Hepatomegaly
- ☐ Inflammatory bowel disease
- ☐ Intrahepatic biliary atresia
- ☐ Laryngomalacia
- ☐ Nausea
- ☐ Pancreatitis
- ☐ Pyloric stenosis
- ☐ Splenomegaly
- ☐ Tracheoesohageal fistula
- ☐ Vomiting
- ☐ Others: _____

Genitourinary Findings

- ☐ Ambiguous genitalia
- ☐ Cryptorchidism
- ☐ Cystic renal dysplasia
- ☐ Horseshoe kidney
- ☐ Hydronephrosis
- ☐ Hypospadias
- ☐ Inguinal hernia
- ☐ Micropenis
- ☐ Nephrolithiasis
- ☐ Polycystic kidney disease
- ☐ Renal agenesis
- ☐ Umbilical hernia
- ☐ Others: _____

Musculoskeletal Findings

- ☐ Abnormal connective tissue
- ☐ Abnormal form of the vertebral bodies
- ☐ Abnormality of the ribs
- ☐ Arachnodactyly
- ☐ Arthralgia
- ☐ Arthrogryposis
- ☐ Bruising susceptibility
- ☐ Clinodactyly
- ☐ Decreased muscle mass
- ☐ Ectrodactyly
- ☐ Exercise intolerance
- ☐ Fatigue
- ☐ Hemihypertrophy
- ☐ Hypertonia
- ☐ Hypotonia
- ☐ Joint hypermobility
- ☐ Muscle weakness
- ☐ Myalgia
- ☐ Myopathic facies
- ☐ Myopathy
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Pain
- ☐ Pectus carinatum
- ☐ Pectus excavatum
- ☐ Polydactyly
- ☐ Recurrent fractures
- ☐ Rhabdomyolysis
- ☐ Scoliosis
- ☐ Short stature
- ☐ Skeletal dysplasia
- ☐ Syndactyly
- ☐ Tall stature
- ☐ Others: _____

Metabolic Findings

(Attached relevant lab reports/values)

- ☐ Abnormal activity of mitochondrial respiratory chain
- ☐ Abnormal Newborn Screen: _____
- ☐ Abnormality of mitochondrial metabolism
- ☐ Elevated CPK
- ☐ Elevated hepatic transaminase
- ☐ Hyperammonemia
- ☐ Hyperglycemia
- ☐ Hypoammonemia
- ☐ Hypoglycemia
- ☐ Increased serum pyruvate
- ☐ Lactic acidosis
- ☐ Plasma AA: _____
- ☐ Urine OA: _____
- ☐ Others: _____

Vascular System

- ☐ Aneurysm
- ☐ Arterial calcification
- ☐ Arterial dissection
- ☐ Arterial tortuosity
- ☐ Arteriovenous malformation
- ☐ Epistaxis
- ☐ Lymphedema
- ☐ Pulmonary hypertension
- ☐ Stroke

Cancer

- ☐ Type: _____
- ☐ Location: _____
- ☐ Age of onset: _____

Other Testing/Imaging

(Please provide copy or report if possible)

- ☐ Echo: _____
- ☐ EEG: _____
- ☐ EMG: _____
- ☐ Gene Panel: _____
- ☐ Results: _____
- ☐ Performed at: _____
- ☐ Gene Sequencing*: _____
- ☐ Results: _____
- ☐ Performed at: _____

If you would like us to comment on the presence / absence of previously identified variants, including parental status (if included), provide complete variant information or a copy of the original report.

- ☐ Microarray: _____
- ☐ MRI: _____
- ☐ Muscle Biopsy: _____
- ☐ Ultrasound: _____
- ☐ X-rays: _____

For Proband

Unique ID _____ Date of birth YYYY / MM / DD

Additional Clinical Findings (Symptoms, previous medical test results, etc.)

Clinical information of family members with similar symptoms (Please include family relation.)

Please inform us of any suspected genes (Please provide the gene name.)