REQUISITION FORM

Unique ID _____ Date of birth YYYY / MM / DD

3B-VARIANT

Patient Profile (For Proband)

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

Previous Test Information

Test Category* ○ 3B-GENOME ○ 3B-EXOME

3billion ID* _____ (e.g. EPE23-ABCD)

Relationship with proband*
○ Father ○ Mother
○ Brother ○ Sister
○ Father's Father ○ Father's Mother
○ Mother's Father ○ Mother's Mother
○ Same individual ○ Other: _____

Patient Information

Sex* ○ Male ○ Female

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

Variant Information

Variant* ○ Primary Finding(s) ○ Secondary Finding(s)

Primary Finding(s)* _____
Genetic variants identified based on the symptoms entered when ordering WGS/WES.

Secondary Finding(s)* _____
Genetic variants found within ACMG-recommended genes in the patient's WGS/WES.

Sample Information

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

Collection date* YYYY / MM / DD

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-VARIANT 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 _____