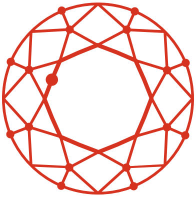

CLARITAS GENOMICS

CLINICAL GENETIC TESTING REQUISITION FORM

CLIA ID#: 22D0950490
Lab Director: Mark D. Kellogg, PhD, DABCC
www.claritasgenomics.com

PATIENT INFORMATION

Last Name ______________________ First Name ______________________ MI ___ MR# ______________

Date of Birth ___/___/_____ MM/DD/YYYY Gender ☐ Male ☐ Female ☐ Unknown

ORDERING PROVIDER

Name ______________________
Email ______________________
Specialty ______________________

Contact numbers
Phone
Fax
Pager

Preferred Primary Contact ☐

ADDITIONAL RESULTS RECIPIENTS

Name ______________________ Specialty ______________________ ☐
Email ______________________

Institution
Name
Address
City State Zip Code

Contact numbers
Phone
Fax
Pager

Name ______________________ Specialty ______________________ ☐
Email ______________________

Institution
Name
Address
City State Zip Code

Contact numbers
Phone
Fax
Pager

Billing Information- All tests and services will be billed to the institution.

Client Code ☐

If you do not have a client code, please call Client Services at 617-553-5880 prior to sending the sample. Testing may be delayed for samples received without a client code.

Test Information

Test(s) ordered 1 ☐ 2 ☐ 3 ☐ ☐ Check for Tiered testing (details below)

Indicate test code for test(s) desired, as found on test menu or on website. To order sequential testing, mark the "Tiered" checkbox above. Claritas will perform the tests following the order of the numbered boxes. For more complex testing, call Claritas directly.

Specimen Type ☐ Blood (3-5mL EDTA) ☐ Skin biopsy ☐ Bone marrow
☐ Extracted DNA - requires prior consultation with laboratory, provide source and extraction method
☐ Other - requires prior consultation with laboratory

Specimen Collection time ___:____ AM/PM (circle one) Date ____________ MM/DD/YYYY

By ordering genetic testing from Claritas Genomics, Inc., you are agreeing to the following:

- Certification that you are a healthcare provider authorized to order genetic testing in the location where you practice.
- Assumption of responsibility for returning the results of genetic testing to your patient and/or legal guardian and for ensuring that your patient receives appropriate genetic counseling to understand the implications of his/her test results.
- Acknowledge that the patient/ legal guardian has been provided information regarding the risks, benefits, and limitations of the test(s) ordered and the patient/ legal guardian has given consent for the ordered test(s) to be performed.

Required Field for New York State (NYS)
Providers NYS providers:
By signing below, the provider confirms the following:

- I have obtained consent from the patient named above or from his/ her guardians, to the full extent of NYS law, for the ordered tests to be performed.
- Upon request, I am able to produce the consent form signed by the patient/guardian.
- I understand that the sample sent to Claritas Genomics will be discarded 60 days from when that sample arrives, or when Claritas issues the final report, whichever occurs later.

SIGNATURE **DATE (MM/DD/YYYY)**

CLARITAS GENOMICS INC. | 99 Erie Street Cambridge, MA 02139 | e: clientservices@claritasgenomics.com | p: 617.553.5880 p: 855.373.9003 f: 617.553.5842
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Clinical Information Form

Detailed information about your patient's clinical findings and history greatly assists the laboratory team in providing accurate and useful results. Please check the box indicating the relevant features below and provide additional information in the marked spaces.

PATIENT NAME: ________________ **DOB:** ________ **MR#** ________________

COGNITIVE/DEVELOPMENTAL/BEHAVIORAL
☐ Global developmental delay
☐ Motor delay: ☐ Gross ☐ Fine
☐ Speech delay
☐ Intellectual disability
☐ Learning disability
☐ Developmental regression
☐ Autism spectrum disorders
☐ Psychiatric symptoms ________________
OTHER ________________

GROWTH
☐ Stature: ☐ Short ☐ Tall
☐ Obesity ☐ Overgrowth
☐ Failure to thrive
☐ Hemihypertrophy ________________
OTHER ________________

HEAD/BRAIN/FACE
☐ Micro- ☐ Macro-cephaly
☐ Abnormal head shape: ____________ cephaly
☐ Craniosynostosis ____________ suture(s)
☐ Brain abnormality: ________________
☐ Micro- ☐ Pro- ☐ Retro-gnathia
☐ Cleft: ☐ Lip ☐ Palate
☐ Abnormality of Mouth ________________
☐ Abnormality of Nose ________________
☐ Abnormality of ☐ Eyes ________ ☐ Vision ________
☐ Hypo- ☐ Hyper-telorism
☐ Abnormality of Eyebrows ________ ☐ Synophrys
☐ Abnormality of Ears ________________
☐ Hearing loss: ☐ Sensorineural ☐ Conductive
☐ Abnormality of Teeth ________________
☐ Abnormality of Neck ________________
☐ Facial asymmetry
☐ Facial: ☐ Palsy ☐ Paralysis ☐ Weakness
OTHER ________________

SKIN/HAIR
☐ Hyper- ☐ Hypo-pigmentation
☐ Café-au-lait spots
☐ Skin: ☐ Tags ☐ Tumors
☐ Ichthyosis
☐ Abnormal Nails ________________
☐ Alopecia
☐ Abnormal Hair: ☐ Quantity ☐ Texture ________
☐ Abnormal Connective Tissue ________________
OTHER ________________

PERINATAL HISTORY
☐ Prematurity ________________ weeks
☐ IUGR
☐ Oligo- ☐ Poly-hydramnios
☐ Cystic hygroma/increased NT
☐ H/o recurrent pregnancy losses

CARDIOVASCULAR
☐ Conotruncal anomaly ________________
☐ Atrial ☐ Ventricular septal defect
☐ Cardiomyopathy: ☐ DCM ☐ HCM ☐ LVNC
☐ Coarctation of aorta
☐ Hypoplastic left heart
☐ Arrhythmia/conduction defect
OTHER ________________

GASTROINTESTINAL
☐ Tracheoesophageal fistula
☐ Gastroschisis
☐ Omphalocele
☐ Hirschsprung disease
☐ Chronic diarrhea
☐ Constipation
☐ Recurrent vomiting
☐ Pyloric stenosis
☐ Gastrointestinal reflux
☐ Anal atresia
☐ Hepato- ☐ Spleno-megaly
OTHER ________________

GENITOURINARY
☐ Kidneys
- ☐ Hydronephrosis
- ☐ Malformation ________________
- ☐ Nephrotic syndrome
- ☐ Tubulopathy
- ☐ Agenesis

☐ Bladder ________________
☐ Ambiguous genitalia
☐ Hypospadias
☐ Cryptorchidism
OTHER ________________

MUSCULAR/NEUROLOGICAL
☐ Seizures Type ________________
☐ Tone: ☐ Hypotonia ☐ Hypertonia
☐ Spasticity
☐ Movement disorder
- ☐ Ataxia
- ☐ Chorea
- ☐ Dystonia

☐ Muscle weakness: ☐ Proximal ☐ Distal
☐ Neurodegeneration
☐ Stroke
☐ Cranial nerve ________________
☐ Sleep disturbance
☐ Headache/migraine
☐ Neural tube defect ________________
☐ Diaphragmatic hernia
☐ Umbilical hernia
OTHER ________________

SKELETAL/LIMB
☐ Limb shortening ☐ Upper ☐ Lower ☐ Right ☐ Left
☐ Limb anomaly ________________
☐ Thumb anomaly ________________
☐ Polydactyly ☐ Pre- ☐ Post-
☐ Syn- ☐ Ectro- ☐ Arachno-dactyly
☐ Small ☐ Large ☐ Hands ☐ Feet
☐ Club foot ☐ Unilateral ☐ Bi-lateral
☐ Scoliosis ☐ Kyphosis ☐ Lordosis
☐ ________________ Fracture(s)
☐ Wormian bones
☐ Vertebral anomaly ________________
☐ Contractures
OTHER ________________

METABOLIC
☐ CPK abnormality
☐ Ketosis
☐ Amino ☐ Organic ☐ -acidemia ☐ -aciduria
Specify ________________
OTHER ________________

ENDOCRINE
☐ Diabetes: ☐ Type I ☐ Type II
☐ Hypo- ☐ Hyper-thyroidism
☐ Hypoparathyroidism
☐ Pheochromocytoma/paraganglioma
OTHER ________________

IMMUNOLOGIC
☐ Immunodeficiency ________________
OTHER ________________

HEMATOLOGIC
☐ Anemia
☐ Neutro- ☐ Pancyto- ☐ Thrombocyto-penia
☐ Increased bleeding
☐ Thrombosis
☐ Transient abnormal myelopoiesis
☐ Juvenile myelomonocytic leukemia
OTHER ________________

MALIGNANCY
Tumor type/Location ________________
Age of onset ________________

PREVIOUS TESTING/RESULT
Chromosomes: ________________
FISH: ________________
Array CGH: DEL ________ DUP ________
Biochemical: ________________
Biopsy: ________________
Imaging: ________________
OTHER: ________________

FAMILY HISTORY: ________________ **ETHNICITY :** ________________

CONSANGUINITY: ☐ **NO** ☐ **YES. IF YES, SPECIFY RELATIONSHIP.** ________________

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