revvity

# Data Generation Requisition Form

Testing can also be ordered via online portal – please scan or click on QR code.
Please complete every field and tick box clearly.

## STEP 1: PATIENT INFORMATION

Patient's First Name | Middle Initial | Patient's Last Name

MM/ DD /YYYY
Patient's Date of Birth | Patient ID/MR Number/External Sample Number

Biological Sex: ○ Male ○ Female ○ Unknown
Gender Identity (if different from above):_____

Patient's Street Address | City / Town

State | Zip Code | Country | Patient's Preferred Phone | Patient's Email

Ethnicity (check all that apply): ○ African-American ○ Asian (China, Japan, Korea) ○ Caucasian/N. European/S. European ○ Finnish ○ French Canadian ○ Hispanic ○ Jewish - Ashkenazi ○ Jewish - Sephardic ○ Mediterranean ○ Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey) ○ Native American ○ E. Indian ○ Southeast Asian (Vietnam, Cambodia, Thailand) ○ South Asian (India, Pakistan) ○ Other (specify)_____

## PATIENT SAMPLE INFORMATION

**SAMPLE TYPE:** ○ Whole Blood ○ Saliva Swab ○ Dried Blood Spots ○ DNA, Source:_____ ○ Other:_____

Collection Date: MM/DD/YY Was this sample collected in the State of NV, NY or OR?: ○ Yes ○ No (If yes, separate consent is required. See forms section of website.)

## INDICATION FOR TESTING

Clinical Diagnosis:_____ (medical records/clinical notes are required.) Age at Initial Presentation:_____

## STEP 2: ORDERING PROVIDER AND REPORTING PREFERENCES

Provider's First and Last Name | NPI

Clinic/Hospital/Institution Name | Provider's Email

Provider's Street Address | City / Town | State | Zip Code | Country

Provider's Phone | Provider's Fax

## SEND ADDITIONAL COPY OF RESULTS TO (If applicable)

Name | Role with patient/Job title | Clinic/Hospital/Institution Name

Phone Number | Fax Number | Email Address

## STEP 3: BILLING INFORMATION

☐ **INSTITUTIONAL BILLING**

Institution/Organization Name | Billing Account ID | P.O. Number (if applicable)

Contact Name | Contact Phone

☐ **PATIENT (SELF) PAYMENT**

By providing payment information, you are authorizing Revvity Omics to process payment at the associated charge for tests ordered. Test cost is available on our website, or may be confirmed by calling 877-475-4436. Payment is required prior to test initiation. The patient's sample will be placed on hold (for up to 30 days) until payment is secured. If the patient does not provide payment to Revvity Omics within 30 days, the test order may be canceled. Please note that failure by the patient to respond in a timely fashion to Revvity Omics attempts to obtain payment may cause a delay in the receipt of the results report.

○ **CREDIT CARD** (Please fill out all information below) ○ **CHECK:** $_____ Amount Enclosed (Please make checks payable to: Revvity Omics, Inc.)

Credit Card Number | MM/YY Exp. Date | CVV | Cardholder Printed Name as Appears on Card | Amount

Credit Card Billing Street Address | City / Town | State | Zip Code

Cardholder Signature | Cardholder Phone

○ **CONTACT FOR PAYMENT INFORMATION**

Name | Phone | Email Address

FOR INTERNAL USE ONLY
Date Rec'd_____ Rec'd _____
TEMP SPEC COL #TUBES VOL
R/C/F
R/C/F
R/C/F

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# Data Generation Requisition Form

## STEP 4: TEST MENU

### WHOLE EXOME SEQUENCING TESTING OPTIONS

○ D1500 Exome - Data Only (per sample)*

### WHOLE GENOME SEQUENCING TESTING OPTIONS

○ D2500 Genome - Data Only (per sample)*

* FASTQ Data Files Only

### DATA DELIVERY TYPE

○ Electronic Transfer

○ Hard Drive+

+ Additional Charges Apply

### PERSON TO RECEIVE DATA

Name: _____

Street Address: _____

City/Town: _____ State:_____ Zip: _____

Phone: _____ Email: _____

## STEP 5: DATA PERMISSIONS*

1. ○ Check here if you would like to opt out of anonymized sample retention. Note, if not checked, this is interpreted as “consent given.”
2. ○ Check here if you would like to opt out of anonymized data retention. Note, if not checked, this is interpreted as “consent given.”
3. ○ Check here if you would like to opt out of your contact information being shared by Revvity to external researchers for direct communication regarding their studies. Note, if not checked, this is interpreted as “consent given.”
4. ○ Check here if sample(s) was or will be collected in the state of NV NY or OR. Additional consent must be completed, which can be found on the Revvity Omics website.

* For more information on data permissions options, please reference Page 4.

## STEP 6: PHYSICIAN CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY

The undersigned person (or designated representative thereof) certifies that: (a) he/she is a licensed medical professional authorized to order the testing ordered herein; (b) he/she fully complies with all applicable federal, state, and local laws, regulations, and rules, including but not limited to those governing genetic testing, informed consent, and patient consent and authorization requirements for the test(s) ordered; (c) he/she will obtain informed consent of the patient in compliance with all applicable laws and regulations, which shall include, to the extent applicable: (i) a statement of the purpose of the test(s) ordered; (ii) a statement that prior to signing the consent form, the consenting person discussed with the medical practitioner ordering the test the reliability of positive or negative test results and the level of certainty that a positive test result for that disease or condition serves as a predictor of such disease; (iii) a statement that the consenting person was informed about the availability and importance of genetic counseling and provided with written information identifying a genetic counselor or medical geneticist from whom the consenting person might obtain such counseling; (iv) a general description of each disease or condition tested for; and (v) the person or persons to whom the test results may be disclosed; (d) he/she will maintain, as part of the patient’s record, documentation of the patient’s informed consent and authorization for the test(s) ordered that complies with applicable laws and regulations, and will make such documentation available to Revvity upon request; (e) tests ordered are medically necessary and results may impact medical management for the patient; and (f) the information provided on this Test Requisition Form is complete, true, and accurate to the best of his/her knowledge.

Signature_____ Date_____