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Targeted Testing 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

How would you like to receive the report?:
○ Fax ○ Email ○ Portal

SEND ADDITIONAL COPY OF RESULTS TO (If applicable)

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

Phone Number | Fax Number | Email Address

How would you like to receive the report?:
○ Fax ○ Email ○ Portal

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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STEP 4: TEST MENU

AnyPanel™ Test

○ D3000 AnyPanel™ Test: Custom Panel
Please submit custom requested gene list for testing at https://apps-omics.revvity.com/gene-dashboard/, and include custom panel ID below
*Provide gene or custom panel ID here:*_____

AnyGene™ Test

○ D3100 AnyGene™ Test: Single Gene Sequencing and Del/Dup Test
Please submit requested gene for testing at https://apps-omics.revvity.com/gene-dashboard/ and include custom gene ID below
*Provide gene or custom panel ID here:*_____

CURATED PANELS

○ Choose any of our multigene disease-specific next-generation sequencing panels. Clinical indications include neuromuscular, neurology, cardiology, hereditary cancer, and other categories such as hearing loss and ophthalmology.

Provide test code here: _____ Provide test name here: _____

CURATED GENOME PANEL BY CLINICAL INDICATION

○ D5238 WholeCancer™ Panel
○ D5239 WholeCardiology™ Panel
○ D5240 WholeAtaxia™ Panel
○ D5241 WholeMuscularDystrophy™ Panel

FSHD TESTING

Test Code	Test Name	Sample Type
○ D8000	FSHD Type 1 Testing (4q D4Z4 repeat size)	WB
○ D5132	FSHD Type 2 Testing	DBS, Saliva, WB, DNA
○ D4035	Comprehensive Neuromuscular Panel (does not include FSHD Type 1)	DBS, Saliva, WB, DNA

IMPORTANT SHIPPING AND HANDLING INSTRUCTIONS

For any order that includes FSHD1 testing, please follow the shipping and handling instructions below to ensure specimens are viable for FSHD1 analysis.
- All samples should be shipped to the lab the same day of draw.
  - Due to the time-sensitive nature of this test, **the sample must arrive in the lab within five days of collection.**
- Please include a completed requisition form marked with appropriate FSHD order to avoid delays in processing. **Date of Collection is a REQUIRED field**.
- The sample should be shipped at refrigeration temperature and include an ice pack within the box. **Do not freeze the specimen.**
  - Please note that shipping conditions can dramatically affect the temperature of sample while in transit.
- If using a Revvity collection pack, please package the specimen in the provided box

OTHER

○ D5137 EURORealTime APOE
○ Other test code: _____ Other test name: _____

FAMILIAL TESTING

○ **D0600** Targeted Single Site Analysis

Proband Last Name, First Name _____ Proband DOB MM/ DD /YYYY

Proband's Accession ID _____ Relationship to Proband _____

Positive Control Sample: ○ Already at Revvity ○ To be sent later ○ Not Available

Gene(s)	Coding Name (c.)	Protein Name (p.)

○ **D0999** Targeted CNV Analysis

Proband Last Name, First Name _____ Proband DOB MM/ DD /YYYY

Proband's Accession ID _____ Relationship to Proband _____

Positive Control Sample: ○ Already at Revvity ○ To be sent later ○ Not Available

Cytoband/Gene	CN Event/Size/Exon	Additional CN Event/Size/Exon

! Please include a copy of relative's report, if available.

STEP 5: 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_____

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Targeted Testing Requisition Form

DETAILED MEDICAL RECORDS, PREVIOUS TEST RESULTS AND FAMILY HISTORY MUST BE ATTACHED FOR ALL CASES.
CLINICAL INFORMATION IS CRUCIAL FOR ACCURATE INTERPRETATION OF RESULTS.

ADDITIONAL PHENOTYPE / PATIENT HISTORY SECTION (Check all that apply)

Clinical diagnosis: _____ Age of manifestation: _____

NEUROLOGY

1. Neurodevelopmental abnormality
- ○ 1.1 Autism
- ○ 1.2 Attention deficit disorder
- ○ 1.3 Global developmental delay
- ○ 1.4 Delayed motor development
- ○ 1.5 Delayed language development
- ○ 1.6 Developmental regression
- ○ 1.7 Intellectual disability

2. Brain imaging
- ○ 2.1 Abnormal myelination
- ○ 2.2 Agenesis of corpus callosum
- ○ 2.3 Brain atrophy
- ○ 2.4 Cerebellar hypoplasia
- ○ 2.5 Heterotopia
- ○ 2.6 Holoprosencephaly
- ○ 2.7 Hydrocephalus
- ○ 2.8 Leukodystrophy
- ○ 2.9 Lissencephaly

3. Movement abnormality
- ○ 3.1 Ataxia
- ○ 3.2 Chorea
- ○ 3.3 Dystonia
- ○ 3.4 Parkinsonism

4. Neuromuscular abnormality
- ○ 4.1 Muscular hypotonia
- ○ 4.2 Muscular hypertonia
- ○ 4.3 Hyperreflexia
- ○ 4.4 Spasticity

5. Seizures
- ○ 5.1 Febrile seizures
- ○ 5.2 Focal seizures
- ○ 5.3 Generalized seizures

6. Others
- ○ 6.1 Craniosynostosis
- ○ 6.2 Dementia
- ○ 6.3 Encephalopathy
- ○ 6.4 Headache / Migraine
- ○ 6.5 Macrocephaly
- ○ 6.6 Microcephaly
- ○ 6.7 Neuropathy
- ○ 6.8 Stroke

METABOLISM
- ○ 1. Elevated creatine kinase
- ○ 2. Decreased plasma carnitine
- ○ 3. Hyperalaninemia
- ○ 4. Hypoglycemia
- ○ 5. Increased CSF lactate
- ○ 6. Increased serum pyruvate
- ○ 7. Ketosis
- ○ 8. Lactic acidosis
- ○ 9. Organic aciduria

EYE
- ○ 1. Blepharospasm
- ○ 2. Cataract
- ○ 3. Coloboma
- ○ 4. Glaucoma
- ○ 5. Microphthalmos
- ○ 6. Nystagmus
- ○ 7. Ophthalmoplegia
- ○ 8. Optic atrophy
- ○ 9. Ptosis
- ○ 10. Retinitis pigmentosa
- ○ 11. Retinoblastoma
- ○ 12. Strabismus
- ○ 13. Visual impairment

MOUTH, THROAT AND EAR
- ○ 1. Abnormality of dental color
- ○ 2. Cleft lip / palate
- ○ 3. Conductive hearing impairment
- ○ 4. External ear malformation
- ○ 5. Hypodontia
- ○ 6. Sensoneural hearing impairment

SKIN, INTEGUMENT AND SKELETAL

1. Skeletal
- ○ 1.1 Abnormal limb morphology
- ○ 1.2 Abnormal vertebral column
- ○ 1.3 Joint hypermobility
- ○ 1.4 Multiple joint contractures
- ○ 1.5 Polydactyly
- ○ 1.6 Scoliosis
- ○ 1.7 Syndactyly
- ○ 1.8 Talipes equinovarus

2. Skin and integument
- ○ 2.1 Abnormal skin pigmentation
- ○ 2.2 Abnormal hair
- ○ 2.3 Abnormal nail
- ○ 2.4 Hyperextensible skin
- ○ 2.5 Ichthyosis

CARDIOVASCULAR
- ○ 1. Angioedema
- ○ 2. Aortic dilatation
- ○ 3. Arrhythmia
- ○ 4. Coarctation of aorta
- ○ 5. Defect of atrial septum
- ○ 6. Defect of ventricular septum
- ○ 7. Dilated cardiomyopathy
- ○ 8. Hypertrophic cardiomyopathy
- ○ 9. Lymphedema
- ○ 10. Malf. of heart and great vessels
- ○ 11. Myocardial infarction
- ○ 12. Tetralogy of Fallot

GASTROINTESTINAL, GENITOURINARY, ENDOCRINE

1. Gastrointestinal
- ○ 1.1 Aganglionic megacolon
- ○ 1.2 Constipation
- ○ 1.3 Diarrhea
- ○ 1.4 High hepatic transaminases
- ○ 1.5 Gastroschisis
- ○ 1.6 Hepatic failure
- ○ 1.7 Hepatomegaly
- ○ 1.8 Obesity
- ○ 1.9 Pyloric stenosis
- ○ 1.10 Vomiting

2. Genitourinary
- ○ 2.1 Hydronephrosis
- ○ 2.2 Renal agenesis /hypoplasia
- ○ 2.3 Renal cyst
- ○ 2.4 Renal tubular dysfunction

3. Endocrine
- ○ 3.1 Diabetes mellitus
- ○ 3.2 Hypothyroidism
- ○ 3.3 Hyperparathyroidism
- ○ 3.4 Hypoparathyroidism
- ○ 3.5 Hyperthyroidism

REPRODUCTION
- ○ 1. Abnormal external genitalia
- ○ 2. Abnormal internal genitalia
- ○ 3. Hypogonadism
- ○ 4. Hypospadias
- ○ 5. Infertility

ONCOLOGY
- ○ 1. Adenomatous polyposis
- ○ 2. Breast carcinoma
- ○ 3. Colorectal carcinoma
- ○ 4. Leukemia
- ○ 5. Myelofibrosis
- ○ 6. Neoplasm of the lung
- ○ 7. Neoplasm of the skin
- ○ 8. Paraganglioma
- ○ 9. Pheochromocytoma

HEMATOLOGY AND IMMUNOLOGY
- ○ 1. Abnormality of coagulation
- ○ 2. Anemia
- ○ 3. Immunodeficiency
- ○ 4. Neutropenia
- ○ 5. Pancytopenia
- ○ 6. Abnormal hemoglobin
- ○ 7. Splenomegaly
- ○ 8. Thrombocytopenia

PRENATAL AND DEVELOPMENT
- ○ 1. Failure to thrive
- ○ 2. Hemihypertrophy
- ○ 3. Hydrops fetalis
- ○ 4. IUGR
- ○ 5. Oligohydramnios
- ○ 6. Overgrowth
- ○ 7. Polyhydramnios
- ○ 8. Premature birth
- ○ 9. Disproportionate short stature
- ○ 10. Proportionate short stature
- ○ 11. Tall stature

OTHER (INCLUDING DYSMORPHIC FACIAL FEATURES AND OTHER DESCRIPTORS):