Reset Form

UCLA Health
Molecular Diagnostics Laboratories

CLINICAL EXOME SEQUENCING REQUISITION & CONSENT

SUBMIT PAGES 1 AND 2 WITH SAMPLES

PATIENT NAME (LAST, FIRST, MI)

CLIENT PATIENT ID	DATE OF BIRTH	GENDER ☐ F ☐ M

ADDRESS:

CITY:	STATE	ZIP CODE	PHONE

ORDERING CLINICIAN/INSTITUTION:

Full Name _____

NPI _____

Institution _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Email _____

Report Copy to _____ Title _____

Phone _____ Fax _____

SPECIMEN INFORMATION

Collection Date:	Collection Time:	Collected By:

INDICATE SPECIMEN TYPE

Specimen must be labeled with at least two patient identifiers

☐ WHOLE BLOOD in lavender top (EDTA) tube (preferred)
Minimum volume: Infant 1-2mL Child or Adult 3-7mL

☐ EXTRACTED DNA (acceptable)

Refer to Specimen requirements at www.pathology.ucla edu/genomics

SELECT CLINICAL EXOME SEQUENCING OPTION

☐ **Individual/Proband only**
☐ **Family Trio (Proband and two family members preferred)**
☐ **Duo (Proband and 1 family member)**
☐ **Quad (Proband and 3 family members)**

If this is a comparator sample:

1) Proband/Child Full Name: _____ DOB: _____
2) Indicate: ☐ Mother ☐ Father ☐ Family member, specify: _____
3) Are all samples submitted on this date? ☐ Yes ☐ No
4) Compared to proband, is this individual similarly affected? ☐ Yes ☐ No

Note: Duo/Trio/Quad testing will begin when all samples and completed paperwork have been received in lab

☐ **Exome re-analysis (attach current clinical note)**

Indicate UCLA case # _____

INDICATE PAYMENT OPTION

☐ **Bill Insurance** Attach demographic sheet with insurance information.
Authorization number (required) _____
For assistance with insurance preverification, please contact Client Services at 310-267-2680'

☐ **Patient Self Pay (Prepayment Required)**
☐ Credit card or wire transfer, please contact our billing office at 310-267-2680
☐ Check / money order made payable to UC Regents

☐ **Bill to Referring Institution (U.S. only)**

Authorized Billing / Business Office Contact Information:

Printed Name: _____ Signature: _____

Email: _____ Phone: _____

Name/Department: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Ordering institution accepts financial responsibility for full price of this test.

Outside of the U.S.: Contact our Billing office at 310-267-2680 for payment via credit card or wire transfer.

ICD DIAGNOSIS CODE(S)

Indicate medical necessity for the test requested.

FOR LAB USE ONLY

Requisition #: _____

CLINICAL INDICATION(S) REQUIRED, ADDITIONAL DESCRIPTION AS APPROPRIATE

☐ Amyotrophic Lateral Sclerosis	☐ Cardiomyopathy	☐ Epilepsy	☐ Primary Immunodeficiency
☐ Ataxia	☐ Congenital Heart Defect	☐ Eye Disorders, unspecified	☐ Retinal Disorders
☐ Autism	☐ Connective Tissue Disorders	☐ Kidney Abnormalities	☐ Sex Development Disorders
☐ Autoimmune Disorders	☐ Craniofacial Abnormalities	☐ Liver Disease	☐ Skeletal Dysplasia
☐ Bleeding/Thrombolytic Disorders	☐ Deafness	☐ Metabolic Disorders	☐ Skin Disorders
☐ Brain Malformation	☐ Developmental Delay	☐ Multiple Congenital Anomalies	☐ Sudden Infant Death
☐ Cancer Susceptibility	☐ Diarrheal Disorders	☐ Muscular Dystrophy	☐ Sudden Unexplained Death
☐ Cardiac Arrhythmia	☐ Endocrine Disorders	☐ Neurologic Disorders, unspecified	☐ Vascular Abnormalities
			☐ Other: _____

Additional Description: _____

Differential Diagnosis: _____

Additional Suspected Gene(s): _____

Use approved gene symbols from HGNC (HUGO Gene Nomenclature Committee http://www.genenames.org)

Ethnicity: ☐ African American ☐ Asian ☐ Ashkenazi Jewish ☐ European Caucasian ☐ Hispanic ☐ Native American Indian ☐ Other Jewish ☐ Other (please specify): _____

Family History:

☐ Congenital Anomalies ☐ Intellectual Disability ☐ Multiple Miscarriages
☐ Parental Consanguinity/degree of relation: _____
☐ Other: _____

DELIVER SAMPLES WITH PAGES 1 & 2 TO UCLA PATHOLOGY OUTREACH SERVICES
10833 LE CONTE AVE, A3-240 CHS, LOS ANGELES, CA 90095-1732 PH 310-267-2680 FX 310-267-2685

UCLA Health

Patient Name: _____

Client Patient ID: _____

Date of Birth: _____

CONSENT FOR POSTNATAL CLINICAL EXOME SEQUENCING TEST

Consent for Postnatal Clinical Exome Sequencing Test Signature Page

This page must be completed and submitted with the requisition before testing can begin.

Option to report medically actionable incidental findings:

Should we report any medically actionable incidental findings we may encounter in the patient? Please check one:

☐ YES ☐ NO

Option for UCLA to use your results:

May we use your results to improve the Clinical Exome Sequencing Test by comparing your data to the data we obtained from other individuals? Please check one:

☐ YES ☐ NO

Statement of Understanding:

I have read (or someone has read to me) the information provided in the Consent for Postnatal Clinical Exome Sequencing Test. I have been given an opportunity to ask questions and all of my questions have been answered about this test. By signing this form, I willingly agree to participate in the Clinical Exome Sequencing Test. (***Signatures are required from each individual to be included in the testing***)

Patient Printed Name: _____

Signature: _____ Date: _____ Time: _____

If signed by an individual other than the patient (or if the patient is a minor), please indicate your relationship to the patient: _____

Printed Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____ Time: _____

Printed Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____ Time: _____

Physician/Genetic Counselor statement: I have explained the Clinical Exome Sequencing Test to this individual. I have addressed the test limitations as outlined on the child's or family member's consent form and have answered this individual's questions about this test.

Physician's or Genetic Counselor's Name: _____

Signature: _____ Date: _____ Time: _____

☐ Signed Chart Copy ☐ Patient Copy

UCLA Health

CONSENT FOR POSTNATAL CLINICAL EXOME SEQUENCING TEST

Patient Name: _____

Client Patient ID: _____

Date of Birth: _____

This document is to provide information about the Clinical Exome Sequencing Test. This information will be discussed with you by a medical geneticist and/or genetic counselor. By signing the Signature Page, you authorize the UCLA Clinical Genomics Center to analyze a sample of your DNA or your child's DNA for the Clinical Exome Sequencing Test.

What is the Benefit of the Clinical Exome Sequencing Test:

The Clinical Exome Sequencing Test is used to identify the genetic cause of a disease or disability in an individual. Genes carry inheritable information, and it is estimated that we have about 20,000 genes in each cell in our body. The combination of all genes in an individual is called the genome. Some important and functional sections of the genome that make protein are called exons. The word 'exome' refers to all exons in the genome. This test analyzes the exons of about 93-97% of all medically relevant genes at the same time and compares it to those of healthy people to identify DNA changes that are related to an individual's medical condition. We do this to try and find the DNA change that has led to your medical condition. The benefit of receiving the information from this test in conjunction with available published medical information at the time of testing is to decide whether these DNA changes are likely to be causing your medical condition.

What are the limitations and risks:

It is important to understand that there may be disease-causing DNA changes (also called incidental findings) that will not be related to your primary clinical concern(s). The symptoms of these other conditions may not be evident at this time, and they may or may not develop in the future. During the course of reviewing your results, we may encounter certain incidental findings which we deem to be medically actionable (where you and/or your physician may want to take action for your future medical benefit). An example of this is variants that are known to be involved in predisposing you to certain types of cancer.

There are also some types of DNA changes that cannot be detected by this test. This test is targeted to analyze the exons; however, there are parts of the exome that are undetectable. In addition, we know that some disease-causing variants do not occur in exons, and this test will not detect those variants either. Your physician may decide that you need other DNA testing in addition to this test. The testing process relies on highly skilled technicians and reliable technology. The methods are reliable, but as with any laboratory test, there is the small chance that an error may occur.

The interpretation of your results will be based on our currently available information. As medical knowledge advances and new discoveries are made, the interpretation of your results may change. It is possible that re-interpretation of your results could lead to new information about your medical condition. Such re-interpretation must be requested by your physician and will involve additional cost. However, it may also not be possible to re-interpret your data at a future date, and it may instead require retesting a new sample from you or your child.

☐ Signed Chart Copy ☐ Patient Copy

UCLA Health

CONSENT FOR POSTNATAL CLINICAL EXOME SEQUENCING TEST

Patient Name: _____

Client Patient ID: _____

Date of Birth: _____

In some instances we might need to test other family members to make the result clear. There is a risk that you may learn other genetic information about you or your family members that is not related to any specific medical concern(s). Learning about this information might cause anxiety and psychological stress. As an example, this test may reveal non-paternity and non-maternity (where the father or mother is not the biological parent) or other unexpected familial relationships.

What is needed:

This test requires 1-2 ml of blood for infants and 3-7 ml (1 teaspoon) of blood for children/adults, which is drawn by needle from a vein.

How long will it take to get the results:

It will take approximately 3 months to obtain results. The results will be sent to your physician. We recommend both pre- and post-test counseling with a clinical geneticist or genetic counselor.

Reporting of the results:

Clinically significant variants associated with your primary clinical concern(s) will be reported to your physician. Variants of uncertain clinical significance which are related to your primary clinical concern(s) may also be reported to your physician (though additional testing of other family members may be recommended to determine the significance of those results).

Alternatives:

An alternative to the Clinical Exome Sequencing test is the sequencing of individual candidate genes, which depends on your medical condition. We recommend discussing other alternatives to the Clinical Exome Sequencing Test with your physician.

Consent for Postnatal Clinical Exome Sequencing Test (Parent or Family Member)

I understand that my child or my family member is having the Clinical Exome Sequencing Test performed at the UCLA Clinical Genomics Center. The physician or the genetic counselor previously discussed the information about this test with me. I have been informed of the potential types of test results and their associated implications. I understand that I am being tested in order to assist with the analysis of my child's or family member's sample and I will not receive a separate report specific to my genetic results. A report will only be generated for my child or family member. If I am found to share the same genetic finding(s) with my child or family member, that information will be included in his/her report.

☐ Signed Chart Copy ☐ Patient Copy