UCSF Genomic Medicine Laboratory (GML)
2340 Sutter Street, N171
San Francisco, CA 94143-1389
Phone: (415) 502-3560
Fax: (415) 476-1356
GML@ucsf.edu (please send email confirmation of orders)

UCSF GML WHOLE EXOME SEQUENCING TEST

Ordering Date:

This test sequences the full coding region of the genome (known as the "exome"). It requires collection of a blood or saliva specimen and often includes the analysis of additional family members. Please load the requisition and patient consent form into APeX scanned clin docs **and** send by email to GML@ucsf.edu. For testing of outside (non-UCSF) specimens, please mail requisition, patient consent and specimens to the address above.

The following components are required:

☐ Test Requisition, including all family members tested (please load into APeX scanned clin docs and send by email to GML@ucsf.edu)

☐ Signed Consent Form (please load into APeX scanned clin docs and send by email to GML@ucsf.edu)

☐ Medical Records (if not in APeX), please indicate any previous genetic test results: ☐ Microarray ☐ Chromosome analysis ☐ Single gene: _____

☐ Detailed Family History and Pedigree (if not in APeX)

☐ Copy of insurance card and pre-authorization (if obtained)

PATIENT INFORMATION

Last name:	First name:	Middle initial:	Birth date:	Medical Record Number:	Patient Gender: ☐ Male ☐ Female ☐ Unknown

Patient Street Address, City, State, Zip code:

ORDERING PROVIDER INFORMATION

Office/Practice/Institution Name:	Ordering Provider Name:	NPI #:	Provider phone no.:
			Provider fax no.:

Practice Street Address, City, State, Zip code:

CLINICAL INDICATION FOR TEST ORDER

Diagnosis:

ICD10 Code(s):

Cardiac disorders: ☐ Arrhythmia ☐ Cardiomyopathy ☐ Sudden infant death & unexplained death ☐ Other:

Congenital anomalies: ☐ Multiple congenital anomalies ☐ Brain/CNS malformations ☐ Congenital disorders of glycosylation ☐ Growth retardation (including IUGR) or short stature ☐ Heart defect / malformation including vascular defect ☐ Hydrocephalus ☐ Hydrops fetalis (non-immune) ☐ Musculoskeletal defects ☐ Renal system abnormalities ☐ Skeletal dysplasia ☐ Other:

Craniofacial disorders: ☐ Craniosynostosis ☐ Cleft lip ☐ Cleft palate ☐ Other:

Neurologic Disorders: ☐ Ataxia ☐ Autism ☐ Dysmorphic features ☐ Hypotonia ☐ Intellectual disability & developmental delay ☐ Muscular dystrophy ☐ Seizures & epilepsy ☐ Other:

Gastrointestinal Disorders: ☐ Esophageal atresia/tracheoesophageal fistula ☐ Gastrointestinal defects ☐ Rectal and large intestinal atresia/stenosis ☐ Other:

Other indications: ☐ Autoimmune disorders ☐ Bleeding/Thrombotic disorders ☐ Cancer susceptibility ☐ Connective tissue disorders ☐ Deafness / ear malformations ☐ Diarrheal disorders ☐ Endocrine disorders ☐ Eye disorders, including retinal disorders ☐ Liver disease ☐ Metabolic Disorders, including mitochondrial ☐ Primary Immunodeficiency ☐ Sexual development disorders ☐ Skin disorders

☐ **Other**:

ADDITIONAL DESCRIPTION:

DIFFERENTIAL DIAGNOSIS:

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

FAMILY HISTORY:

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

☐ Other:____

GEOGRAPHIC ANCESTRY:

SPECIMEN INFORMATION

Blood in EDTA, Minimum volume: Infant 1-2 cc; Child or Adult 3-7 cc

Extracted DNA: High molecular weight genomic DNA extracted from whole blood & treated with RNase, Minimum 10µg at 100ng/mL

PATIENT	Specimen Type: ☐ Blood in EDTA ☐ Saliva ☐ Buccal swab ☐ Extracted DNA		Collection date: Collection time:		
FAMILY MEMBER	Specimen Type: ☐ Blood in EDTA ☐ Saliva ☐ Buccal swab ☐ Extracted DNA Collection date:	Last name: Relationship to patient:	First name: Relevant Symptoms:	Middle initial:	Date of birth:
FAMILY MEMBER	Specimen Type: ☐ Blood in EDTA ☐ Saliva ☐ Buccal swab ☐ Extracted DNA Collection date:	Last name: Relationship to patient:	First name: Relevant Symptoms:	Middle initial:	Date of birth:
FAMILY MEMBER	Specimen Type: ☐ Blood in EDTA ☐ Saliva ☐ Buccal swab ☐ Extracted DNA Collection date:	Last name: Relationship to patient:	First name: Relevant Symptoms:	Middle initial:	Date of birth:

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INSURANCE INFORMATION

(Attach copy of insurance AUTHORIZATION)

(Attach copy of insurance card. If not available, complete the following)

Policy holder's name:	Birth date:	Plan name:	Policy no.:	Group no.:
Policy holder's Street Address, City, State, Zip code (if different):				
Name of insurance company:	Insurance company phone number:			
Insurance Street Address, City, State, Zip code:				