

CONTRACT #		LL: K012-01		<b>LifeLabs Demographic Label</b>			
Report to Physician #		Physician OHIP# (Ontario): Physician MSC# (British Columbia): Other Provinces: 999					
Ordering Physician Name		Name					
Ordering Physician Address & Contact Info:		Address Tel: _____ Fax: _____					
Physician Signature:		<p><b>Confirmation of patient consent:</b> I confirm that this patient has given consent to testing as may be required by applicable law, which indicates that: the patient has been informed about the details associated with the genetic test(s) ordered below including its risks, benefits and limitations; I/we will ensure that test results will be interpreted to the patient in an appropriate manner, and that the patient will not receive the results without accompanying counseling; and the patient was informed that s/he has the right to revoke his/her consent at any time. I/we confirm that the patient is legally capable of providing this consent, all questions have been answered and the patient has had the necessary consideration time.</p>				<b>Additional Label (if needed)</b>	
Copy to: <input type="checkbox"/> Genetic Counsellor <input type="checkbox"/> Other Healthcare Provider		Copy to name Tel: _____ Fax: _____					
Bill to:		Contract # K012-01 (patient does not pay at time of collection)					
Provincial Health Card #:						Patient Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Patient Last Name:			Patient First Name:			Date of Birth:	
						M M D D Y Y Y Y	
Unit #:	Street:	City:	Prov.:	Postal Code:	Patient Telephone #:		

**For samples not collected at a LifeLabs location, please ship all NON-PRENATAL samples to:**  
LifeLabs · Attn SPECIMEN MANAGEMENT Department • 37 Voyager Court N. • Toronto ON • M9W 6J2

TEST REQUESTED				LL TR	MNEMONIC
Sample Type:	<input type="checkbox"/> Genetic Test - Blood Sample 2 x 4mL EDTA <input type="checkbox"/> Genetic Test (Pediatric) - Blood Sample 1 x 2mL EDTA <input type="checkbox"/> Genetic Test - DNA (1-10ug) <input type="checkbox"/> Genetic Test - Filter card (available by request) <input type="checkbox"/> Genetic Test - Other: _____ <b>PRENATAL SAMPLES: Please ship directly to CENTOGENE</b>			4005 4008 4014 4014 4014	ACG CEN OCG OCG OCG
Date Sample Collected:	M M D D Y Y Y Y	Time Collected:	H H M M	Collector Name:	
Test Selection:	<b>Sequencing</b> – select ONE of the following options:  <input type="checkbox"/> <b>Centoxome Gold</b> 70-100x average coverage (~95% targeted bases covered >10X) ▪ Turnaround time <55 working days ▪ No prenatal testing available  <input type="checkbox"/> <b>Centoxome Platinum</b> 100-130x average coverage (~95% targeted bases covered >20X) ▪ Turnaround time <15 working days ▪ Prenatal testing available			<b>Number of samples</b> – select ONE of the following options: <input type="checkbox"/> <b>Solo</b> Solo implies analysis of index patient only; we recommend Trio analysis for enhanced diagnostic accuracy. <input type="checkbox"/> <b>Trio</b> Trio implies analysis of index patient along with the parents. <input type="checkbox"/> <b>Trio Plus</b> "Trio plus" indicates "Trio" plus additional relatives. All Trio samples have to be received simultaneously to start testing, else each sample from the same family will be charged as Solo.	
	<b>Sequence analysis data exchange:</b> <input type="checkbox"/> fastq files <input type="checkbox"/> bam files <input type="checkbox"/> vcf Raw data (fastq and bam files) is available only for a limited time and must be downloaded from the server within 1 month after the customer is informed of the completion of the analysis or after the final medical report has been issued. <input type="checkbox"/> <b>Data selected above with annotated and filtered variant report</b> - filtered variant report as Excel table				
Ordering checklist <i>Each of these are mandatory for Whole Exome Sequencing</i>	<input type="checkbox"/> <b>Proband requisition</b> <input type="checkbox"/> <b>Clinical Features checklist completed (bottom of page 2)</b> <input type="checkbox"/> <b>Informed consent</b> <input type="checkbox"/> <b>Parental 1 requisition (if Trio selected)</b> <input type="checkbox"/> <b>Parental 2 requisitions (if Trio selected)</b> <input type="checkbox"/> <b>Additional Family Member requisitions (if TrioPlus selected OR Parental samples unavailable)</b>				

**\*\*PHOTOCOPY REQUISITION AND INCLUDE 1 COPY WITH SAMPLES\*\***

<b>Patient Name:</b>		<b>Patient DOB (MM/DD/YYYY):</b>	
<b>Billing Status:</b>	<input type="checkbox"/> Ministry of Health Approved (Approval letter attached)	<input type="checkbox"/> Private Pay (Complete information below)	
	<input type="checkbox"/> Ministry of Health Approval Pending	<input type="checkbox"/> Institution (Complete information below)	
<b>Institution Billing ONLY:</b>	<b>Institution Name:</b> _____ <b>Contact Name:</b> _____ <b>Address:</b> _____  <b>Phone:</b> (____) _____ - _____ <b>Fax:</b> (____) _____ - _____ <b>Email:</b> _____		
<b>Private Pay ONLY:</b>	Please complete the "Centogene Whole Exome – Private Pay Payment Authorization" form		
<b>Patient Information:</b>	<input type="checkbox"/> African <input type="checkbox"/> Caucasian <input type="checkbox"/> French Canadian or Cajun <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Northern European e.g. British, German <input type="checkbox"/> South Asian e.g. Indian, Pakistani <input type="checkbox"/> East Asian e.g. Chinese, Japanese <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Other/Mixed Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Southern European e.g. Italian, Greek <input type="checkbox"/> Southeast Asian e.g. Filipino, Vietnamese <input type="checkbox"/> Pacific Islander		
	<b>Relevant medical and family history:</b>		

**CLINICAL FEATURES CHECKLIST**

<b>Cardiovascular</b> <input type="checkbox"/> Angioedema <input type="checkbox"/> Aortic dilatation <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Coarctation of aorta <input type="checkbox"/> Defect of atrial septum <input type="checkbox"/> Defect of ventral septum <input type="checkbox"/> Dil. Cardiomyopathy <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypertroph. Cardiomyopathy <input type="checkbox"/> Hypotension <input type="checkbox"/> Long QT syndrome <input type="checkbox"/> Lymphedema <input type="checkbox"/> Mal. of heart and great vessels <input type="checkbox"/> Myocardial infarction <input type="checkbox"/> Stroke <input type="checkbox"/> Tetralogy of Fallot <input type="checkbox"/> Vasculitis/angiitis	<input type="checkbox"/> Cortical dysplasia <input type="checkbox"/> Craniosynostosis <input type="checkbox"/> Delayed motor milestones <input type="checkbox"/> Delayed speech <input type="checkbox"/> Dementia <input type="checkbox"/> Development regression <input type="checkbox"/> Dystonia <input type="checkbox"/> Encephalopathy <input type="checkbox"/> Epilepsy, febrile <input type="checkbox"/> Epilepsy, focal <input type="checkbox"/> Epilepsy, generalized <input type="checkbox"/> Headache/Migraine <input type="checkbox"/> Heteropia <input type="checkbox"/> Holoprosencephaly <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Hyperflexia <input type="checkbox"/> Intellectual disability <input type="checkbox"/> Leukodystrophy <input type="checkbox"/> Lissencephaly <input type="checkbox"/> Macrocephaly <input type="checkbox"/> Muscular hypertonía <input type="checkbox"/> Muscular hypotonia <input type="checkbox"/> Neuropathy <input type="checkbox"/> Parkinson <input type="checkbox"/> Psychiatric syndromes <input type="checkbox"/> Spasticity <input type="checkbox"/> Stroke	<b>Ophthalmological</b> <input type="checkbox"/> Blepharospasm <input type="checkbox"/> Cataract <input type="checkbox"/> Coloboma <input type="checkbox"/> Glaucoma <input type="checkbox"/> Microphthalmos <input type="checkbox"/> Nystagmus <input type="checkbox"/> Ophthalmoplegia <input type="checkbox"/> Optic atrophy <input type="checkbox"/> Ptosis <input type="checkbox"/> Retinitis pigmentosa <input type="checkbox"/> Retinoblastoma <input type="checkbox"/> Strabismus <input type="checkbox"/> Vision loss	<input type="checkbox"/> Syndactyly <input type="checkbox"/> Talipes equinovarus <input type="checkbox"/> Vertebral anomaly <b>Metabolic</b> <input type="checkbox"/> Abnormal creatine kinase <input type="checkbox"/> CSF lactate increase <input type="checkbox"/> Decreased plasma carnitine <input type="checkbox"/> Elevated alanine <input type="checkbox"/> Elevated pyruvate <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Ketosis <input type="checkbox"/> Lactic acidemia <input type="checkbox"/> Organic aciduria <b>Liver/Kidney/Endocrinology/Gastrointestinal</b> <input type="checkbox"/> Abnormal renal morphology <input type="checkbox"/> Abnormal urinary system <input type="checkbox"/> Aganglionic megacolon <input type="checkbox"/> Constipation <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Diarrhea <input type="checkbox"/> Elevated transaminases <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Hepatic failure <input type="checkbox"/> Hepatomegaly <input type="checkbox"/> Hydronephrosis <input type="checkbox"/> Hyper/hypothyroidism <input type="checkbox"/> Hypo/hyperparathyroidism <input type="checkbox"/> Hypoparathyroidism <input type="checkbox"/> Obesity <input type="checkbox"/> Paraganglioma <input type="checkbox"/> Pheochromocytoma <input type="checkbox"/> Pyloric stenosis	<input type="checkbox"/> Recurrent vomiting <input type="checkbox"/> Renal agenesis <input type="checkbox"/> Renal cyst <input type="checkbox"/> Renal tubulopathy <b>Tumoral and haematological</b> <input type="checkbox"/> Abnormal hemoglobin <input type="checkbox"/> Adenomatous polyposis <input type="checkbox"/> Brain tumor <input type="checkbox"/> Breast cancer <input type="checkbox"/> Coagulation disorder <input type="checkbox"/> Colorectal tumor <input type="checkbox"/> Immunodeficiency <input type="checkbox"/> Leukemia <input type="checkbox"/> Lung tumor <input type="checkbox"/> Melanoma <input type="checkbox"/> Myelofibrosis <input type="checkbox"/> Neutropenia <input type="checkbox"/> Pancytopenia <input type="checkbox"/> Splenomegaly <input type="checkbox"/> Thrombocytopenia <b>Prenatal and Development</b> <input type="checkbox"/> Hemihypertrophy <input type="checkbox"/> Hydrops fetalis <input type="checkbox"/> Oligohydramnios <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Intrauterine growth restriction <input type="checkbox"/> Overgrowth <input type="checkbox"/> Polyhydramnios <input type="checkbox"/> Premature birth <input type="checkbox"/> Short Stature <input type="checkbox"/> Tall Stature
<b>Mouth, Throat, and Ear</b> <input type="checkbox"/> Abnormality of dental color <input type="checkbox"/> Cleft lip/palate <input type="checkbox"/> Ear malformation <input type="checkbox"/> Hearing impairment <input type="checkbox"/> Hypodontia	<input type="checkbox"/> Abn. external genitalia <input type="checkbox"/> Abnormal internal genitalia <input type="checkbox"/> Hypogonadism <input type="checkbox"/> Hypospadias <input type="checkbox"/> Infertility	<b>Bone, Skin and immune</b> <input type="checkbox"/> Abnormal hair <input type="checkbox"/> Abnormal nails <input type="checkbox"/> Abnormal pigmentation <input type="checkbox"/> Anemia <input type="checkbox"/> Club foot <input type="checkbox"/> Dysmorphic features <input type="checkbox"/> Hyperextensible skin <input type="checkbox"/> Ichthyosis <input type="checkbox"/> Ichthyosis <input type="checkbox"/> Joint contractures <input type="checkbox"/> Joint hypermobility <input type="checkbox"/> Limp malformation <input type="checkbox"/> Pancytopenia <input type="checkbox"/> Polydactyly <input type="checkbox"/> Scoliosis <input type="checkbox"/> Skeletal abnormalities <input type="checkbox"/> Skin tumors		

**\*\*PHOTOCOPY REQUISITION AND INCLUDE 1 COPY WITH SAMPLES\*\***

**Patient Name:**

**Patient DOB (MM/DD/ YYYY):**

## Clinical Exome Sequencing – Informed Consent (page 1 of 2)

### What are Genetic Tests and Whole Exome Sequencing Tests?

Your physician has recommended for you (or a person for whom you have custody and are caring for) a genetic analysis to clarify your diagnosis/symptoms. A **genetic test** studies the inherited substance (DNA) using a molecular-genetic analysis of characteristics, which may be the cause of the disease that has occurred or is suspected in you or your family. In a genetic test, depending on the case, individual genetic characteristics for a specific condition are analyzed or many genetic characteristics are investigated at the same time using an overview method (e.g. using exome or genome sequencing).

The **study material** is usually a blood sample. Normally there are no health risks when taking a blood sample. Sometimes blood can bruise (hematoma) at the drawing site or very rarely there could be nerve damage. Another risk, although highly unlikely, is the possibility of the samples being swapped. Every effort is made to avoid this and other mistakes.

A new form of genetic testing called **Whole Exome Sequencing** (WES) identifies changes in DNA by focusing on the most informative regions of the genome. The exome is the collection of those DNA sequences of the genes which determine the production of proteins, which your body needs in order to function properly. Most of the disease causing mutations that science has been able to pinpoint so far are located in exons. Whereas most genetic tests focus on a single gene or a set number of predetermined genes, WES tests examine thousands of genes simultaneously. The sample and the test results will be used for the analysis and in accordance with your consent declaration that is stated below. The test results will also be used - if possible - for treatment decisions by your physician(s).

### Test Results

When an exome sequence is analyzed, it is compared to the reference human genome. While there are always certain variations, depending upon the individual and the data available, CENTOGENE reports only disease causing mutations, which can be found by comparing data with medical databases and looking for scientific links. If your WES test reveals any potentially disruptive variations or problems which may be related to your medical condition, this would be reported to your physician.

A medical report may include information that is considered to be important because this is of direct and immediate relevance, either to your own health or to that of family members who share part of your genetic background. CENTOGENE adheres to the guidelines set out by the American College of Medical Genetics (ACMG), which allow for reporting specific types of medically actionable or incidental/secondary findings (PMID: 23788249). Centogene will not report on findings not directly related to the cause of a disease and not listed in the ACMG guidelines.

If a disease causing mutation is demonstrated, this result is usually highly conclusive. If no disease-causing mutation is found, genetic changes responsible for the disease may still exist. A genetic disease or tendency to have a disease can therefore not usually be fully excluded. Sometimes gene variants are proven but their significance is not clear. This is stated in the results and discussed with you. A comprehensive explanation of all possible causes of diseases due to genetic reasons is not possible. It is also not possible to exclude every disease risk for yourself and your family members (especially your children) utilizing genetic analyses.

### Findings confirmed by Sanger sequencing

All variants which do not fulfill the quality parameters established for 100% accuracy are confirmed by Sanger sequencing.

### Use of parental samples in the testing process of WES

Biological parental samples are used to improve the interpretation of the final results in WES testing. In Trio analysis WES testing and bioinformatic analyses on parental samples is done in parallel to the analysis of the index patient. We check the parents' material (based on the exome sequencing data) only with regard to the patient's condition. If several family members are tested, accurate interpretation of the results depends on the assumed relationships being correct. If doubt is created by the genetic analysis about the apparent relationships, we will not inform you. An exception will be made if it is absolutely necessary for the completion of the requested test.

### Right of revocation

You can withdraw your consent to the analysis at any time in full or in part without stating reasons. You have the right not to be informed about test results (right not to know), to stop the testing processes that have been started at any time up to being given the results and to request the destruction of all test material and all results collected up to that time. If an exome test is **cancelled prior to test set-up, Centogene charges a processing fee and will send a cancellation report. Once testing is initiated, the full price of the analysis will be charged.**

### WES Limitations

WES testing does not analyze all genes in the human genome. Some genes cannot be examined because of various technical reasons. Approximately 5% of the targeted exons may not be well covered due to insufficient coverage due to various technical reasons. Extent of analysis is dependent on the chosen Gold or Platinum quality.

Certain mutation types may not be detectable ( for eg. large copy number variations, methylation, trinucleotide repeat expansions, etc.) This means that you can be affected with a certain condition, but that WES testing does not identify or reveal this.

The raw filtered variant may include secondary findings and variants that may be potential sequencing artefacts.

The knowledge of the results may result in mental stress. It is always recommended to discuss the details of the genetic report with your local doctor.

**Patient Name:** \_\_\_\_\_

**Patient DOB (MM/DD/YYYY):** \_\_\_\_\_

## Clinical Exome Sequencing – Informed Consent (page 2 of 2)

**Sections 1, 2, + 3 below require completed checkboxes or signatures from the patient-** *It is mandatory to ensure that a patient has signed his or her consent to conduct genetic analysis.*

### 1. Incidental Findings

As our whole exome sequencing test is analyzing many different genes, there is a potential for the recognition of incidental or secondary findings unrelated to the reason for ordering WES. These findings can provide information that was not anticipated and that are unrelated to your reported clinical features, but are of medical value for your care. Typically these diseases can be categorized as:

- 1) a predisposition to increased cancer risk;
- 2) carrier status of recessive diseases;
- 3) a predisposition to late-onset diseases.

Yes

No

Centogene reports mutations of the specified classes or types in the genes listed in the "ACMG Recommendations for Reporting of Incidental Findings" in clinical exome sequencing report. **Do you agree to receive information regarding genetic results that are unrelated to the specific reason for which my healthcare provider ordered the test?**

### 2. LifeLabs

I understand that my specimen for DNA analysis will be sent to LifeLabs for genetic testing. I am aware that correct information about the relationships between my family members is important. I agree that my specimen and personal health information may be sent to Centogene AG at their laboratory in Germany (address above). To facilitate accurate testing, I agree that the results of genetic testing that I have had previously completed by Centogene AG may be shared with LifeLabs. I understand that LifeLabs will contact me for a new specimen if a test result cannot be provided from the original specimen. I agree that a copy of my results will be sent to my ordering physician. I further agree that for any test(s) performed by Centogene AG, a copy of my results will also be sent to LifeLabs

**Patient/Substitute Decision Maker: Signature:** \_\_\_\_\_ ; **Date:** \_\_\_\_\_

**Printed name:** \_\_\_\_\_ ; **Relationship to person being tested:** \_\_\_\_\_

**OR: I certify that verbal consent was obtained from the patient /substitute decision maker for the requested genetic testing**

**Signature of Physician :** \_\_\_\_\_ ; **Date:** \_\_\_\_\_

### 3. Declaration of Consent for the Performance of a Genetic Analysis

**I confirm that I have read pages 1 and 2 of the Informed Consent.** I consent to the carrying out of the genetic analysis indicated on these pages, on myself or the person I am custodian for. My physician has told me about the condition(s) being investigated and its genetic basis. I have received, read and understood a written explanation of genetic analyses. I agree to the recording of my personal data, especially my name, date of birth and relationship to other family members and of required medical data, in accordance with data protection regulations. CENTOGENE will store personal data and medical results for 20 years with a signed consent. Your personal data, medical results and sample are subject to medical confidentiality, and can only be disclosed with your written consent, other than as permitted or required by law. I consent to the storage and use of my test results stipulated by legal and regulatory guidelines for the given period until I revoke my consent in written form to CENTOGENE. I further agree that the result(s) of the analysis may be recorded for purposes of their transmittal to me or my attending physician in accordance with applicable privacy law. I have been comprehensively informed by my physician of the medical and psychological consequences. I also confirm that I will receive genetic counseling to help me understand the impact and consequences of my diagnostic results.

1. I understand that once the requested test(s) has/have been completed, any remaining sample will be stored at the testing laboratory at no additional charge.
2. I agree that my de-identified sample may be used for product development, quality assurance, or research purposes. I understand that I will not receive any royalties, resultant payments, benefits or rights to products or discoveries.
3. I consent to the storage and use of my pseudonymized (encrypted) or de-identified test results in a statistical database for scientific purposes and to facilitate and improve the diagnosis of genetic changes and diseases in other patients.
4. I consent that my de-identified results stored in the database are being provided to physicians, scientists and researchers for the purposes of researching genetic diseases and improving their diagnostics and treatment.

I do not want my remaining sample or data from my results to be stored and/or used for product development or research purposes. Please destroy any remaining sample once the final report has been issued. By ticking this box I disagree with points 1, 2, 3 and 4 listed above.

**Patient/Substitute Decision Maker: Signature:** \_\_\_\_\_ ; **Date:** \_\_\_\_\_

**Printed name:** \_\_\_\_\_ ; **Relationship to person being tested:** \_\_\_\_\_

1-844-363-4357  
Ask.Genetics@LifeLabs.com

Appointment booking can be done at [www.lifelabs.com](http://www.lifelabs.com)

Schillingallee 68 · 18057 Rostock Germany

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<b>Report to Physician #</b>	Physician OHIP# (Ontario): Physician MSC# (British Columbia): Other Provinces: 999											
<b>Ordering Physician Name</b>	Name											
<b>Ordering Physician Address &amp; contact info:</b>	Address		<b>Additional LifeLabs Label (if needed)</b>									
	Tel: _____ Fax: _____											
<b>Physician Signature:</b>												
<b>Copy to :</b>	Copy to name _____		<input type="checkbox"/> Genetic Counsellor <input type="checkbox"/> Other Healthcare Provider									
	Tel: _____ Fax: _____											
<b>Bill to:</b>	Contract # K012-01 (patient does not pay at time of collection)											
<b>Provincial Healthcard #:</b>			<b>Patient Sex:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male									
<b>Patient Last Name:</b>	<b>Patient First Name:</b>		<b>Patient DOB:</b>									
			<table border="1" style="width: 100%; text-align: center;"> <tr> <td>M</td><td>M</td><td>D</td><td>D</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>		M	M	D	D	Y	Y	Y	Y
M	M	D	D	Y	Y	Y	Y					
<b>Unit #:</b>	<b>Street:</b>	<b>City:</b>	<b>Prov.:</b>	<b>Postal Code:</b>	<b>Patient Telephone #:</b>							
					( ) -							

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TEST REQUESTED								
<b>Sample Type:</b>	<input type="checkbox"/> Genetic Test - Blood Sample 2 x 4mL EDTA <input type="checkbox"/> Genetic Test (Pediatric) - Blood Sample 1 x 2mL EDTA <input type="checkbox"/> Genetic Test – DNA (1-10ug) <input type="checkbox"/> Genetic Test – Filter card (available by request) <input type="checkbox"/> Genetic Test – Other: _____ <b>PRENATAL SAMPLES:</b> Please ship directly to CENTOGENE			<b>ON-LL TR#</b>	<b>Mnemonic</b>			
				4005	ACG			
				4008	CEN			
				4014	OCG			
				4014	OCG			
				4014	OCG			
<b>Date Sample Collected:</b>	M	M	D	D	Y	Y	Y	Y
<b>Time Collected:</b>	H	H	M	M	<b>Collector Name:</b>			
CENTOXOME® PARENTALS (must accompany "Whole Exome Sequencing – Proband")								
<b>Proband Name:</b>								
<b>Parental Information:</b>	<input type="checkbox"/> African <input type="checkbox"/> Caucasian <input type="checkbox"/> French Canadian or Cajun <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Northern European e.g. British, German <input type="checkbox"/> South Asian e.g. Indian, Pakistani <input type="checkbox"/> East Asian e.g. Chinese, Japanese		<input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Other/Mixed Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Southern European e.g. Italian, Greek <input type="checkbox"/> Southeast Asian e.g. Filipino, Vietnamese <input type="checkbox"/> Pacific Islander					
	<b>Additional patient medical information:</b>							
	<b>Is relative affected with symptoms?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>If Yes, please describe:</b>   <b>Relevant family history:</b>							

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<b>Ordering Physician Name</b>	Name			
<b>Ordering Physician Address &amp; contact info:</b>	Address		<b>Additional LifeLabs Label (if needed)</b>	
	Tel: _____ Fax: _____			
<b>Physician Signature:</b>				
<b>Copy to :</b>	Copy to name _____		<input type="checkbox"/> Genetic Counsellor	
	Tel: _____ Fax: _____		<input type="checkbox"/> Other Healthcare Provider	
<b>Bill to:</b>	Contract # K012-01 (patient does not pay at time of collection)			
<b>Provincial Healthcard #:</b>			<b>Patient Sex:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	
<b>Patient Last Name:</b>	<b>Patient First Name:</b>		<b>Patient DOB:</b>	
			M	M
			D	D
			Y	Y
			Y	Y
<b>Unit #:</b>	<b>Street:</b>	<b>City:</b>	<b>Prov.:</b>	<b>Postal Code:</b>
				<b>Patient Telephone #:</b>
				( ) -

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TEST REQUESTED					
<b>Sample Type:</b>	<input type="checkbox"/> <b>Genetic Test - Blood Sample</b> 2 x 4mL EDTA <input type="checkbox"/> <b>Genetic Test (Pediatric) - Blood Sample</b> 1 x 2mL EDTA <input type="checkbox"/> <b>Genetic Test - DNA</b> (1-10ug) <input type="checkbox"/> <b>Genetic Test - Filter card</b> (available by request) <input type="checkbox"/> <b>Genetic Test - Other:</b> _____ <u>PRENATAL SAMPLES:</u> Please ship directly to CENTOGENE			<b>ON-LL TR#</b>	<b>Mnemonic</b>
				4005	ACG
				4008	CEN
				4014	OCG
				4014	OCG
				4014	OCG
<b>Date Sample Collected:</b>	M	M	D	D	Y
<b>Time Collected:</b>	H	H	M	M	
<b>Collector Name:</b>					

CENTOXOME® PARENTALS (must accompany "Whole Exome Sequencing - Proband")			
<b>Proband Name:</b>			
<b>Parental Information:</b>	<table border="0"> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> African  <input type="checkbox"/> Caucasian  <input type="checkbox"/> French Canadian or Cajun  <input type="checkbox"/> Middle Eastern  <input type="checkbox"/> Northern European e.g. <i>British, German</i>  <input type="checkbox"/> South Asian e.g. <i>Indian, Pakistani</i>  <input type="checkbox"/> East Asian e.g. <i>Chinese, Japanese</i> </td> <td style="vertical-align: top;"> <input type="checkbox"/> Ashkenazi Jewish  <input type="checkbox"/> Other/Mixed Caucasian  <input type="checkbox"/> Native American  <input type="checkbox"/> Hispanic  <input type="checkbox"/> Southern European e.g. <i>Italian, Greek</i>  <input type="checkbox"/> Southeast Asian e.g. <i>Filipino, Vietnamese</i>  <input type="checkbox"/> Pacific Islander           </td> </tr> </table>	<input type="checkbox"/> African <input type="checkbox"/> Caucasian <input type="checkbox"/> French Canadian or Cajun <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Northern European e.g. <i>British, German</i> <input type="checkbox"/> South Asian e.g. <i>Indian, Pakistani</i> <input type="checkbox"/> East Asian e.g. <i>Chinese, Japanese</i>	<input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Other/Mixed Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Southern European e.g. <i>Italian, Greek</i> <input type="checkbox"/> Southeast Asian e.g. <i>Filipino, Vietnamese</i> <input type="checkbox"/> Pacific Islander
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	<b>Additional patient medical information:</b>  <b>Is relative affected with symptoms?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>If Yes, please describe:</b>  <b>Relevant family history:</b>		

1-844-363-4357 [Ask.Genetics@LifeLabs.com](mailto:Ask.Genetics@LifeLabs.com)

Appointment booking can be done at [www.lifelabs.com](http://www.lifelabs.com)

Schillingallee 68 · 18057 Rostock Germany

<b>CONTRACT #</b>	<b>LL: K012-01 / BC: no contract#</b>		<b>LifeLabs Demographic Label</b>							
<b>Report to Physician #</b>	Physician OHIP# (Ontario): Physician MSC# (British Columbia): Other Provinces: 999									
<b>Ordering Physician Name</b>	Name									
<b>Ordering Physician Address &amp; contact info:</b>	Address		<b>Additional LifeLabs Label (if needed)</b>							
	Tel: _____ Fax: _____									
<b>Physician Signature:</b>										
<b>Copy to :</b>	Copy to name _____		<input type="checkbox"/> Genetic Counsellor <input type="checkbox"/> Other Healthcare Provider							
	Tel: _____ Fax: _____									
<b>Bill to:</b>	<b>Contract # K012-01</b> (patient does not pay at time of collection)									
<b>Provincial Healthcard #:</b>				<b>Patient Sex:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male						
<b>Patient Last Name:</b>	<b>Patient First Name:</b>		<b>Patient DOB:</b>							
			M	M	D	D	Y	Y	Y	Y
<b>Unit #:</b>	<b>Street:</b>	<b>City:</b>	<b>Prov.:</b>	<b>Postal Code:</b>	<b>Patient Telephone #:</b>					
					( ) -					

**For samples not collected at a LifeLabs location, please ship all NON-PRENATAL samples to:**  
LifeLabs · Attn SPECIMEN MANAGEMENT Department • 37 Voyager Court N. • Toronto ON • M9W 6J2

TEST REQUESTED														
<b>Sample Type:</b>	<input type="checkbox"/> <b>Genetic Test - Blood Sample</b> 2 x 4mL EDTA <input type="checkbox"/> <b>Genetic Test (Pediatric) - Blood Sample</b> 1 x 2mL EDTA <input type="checkbox"/> <b>Genetic Test – DNA</b> (1-10ug) <input type="checkbox"/> <b>Genetic Test – Filter card</b> (available by request) <input type="checkbox"/> <b>Genetic Test – Other:</b> _____ <b>PRENATAL SAMPLES:</b> Please ship directly to CENTOGENE					<b>ON-LL TR#</b>	<b>Mnemonic</b>							
						4005	ACG							
						4008	CEN							
						4014	OCG							
						4014	OCG							
						4014	OCG							
<b>Date Sample Collected:</b>	M	M	D	D	Y	Y	Y	<b>Time Collected:</b>	H	H	M	M	<b>Collector Name:</b>	

CENTOXOME® PARENTALS (must accompany “Whole Exome Sequencing – Proband”)	
<b>Proband Name:</b>	
<b>Parental Information:</b>	<input type="checkbox"/> African <input type="checkbox"/> Caucasian <input type="checkbox"/> French Canadian or Cajun <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Northern European e.g. <i>British, German</i> <input type="checkbox"/> South Asian e.g. <i>Indian, Pakistani</i> <input type="checkbox"/> East Asian e.g. <i>Chinese, Japanese</i> <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Other/Mixed Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Southern European e.g. <i>Italian, Greek</i> <input type="checkbox"/> Southeast Asian e.g. <i>Filipino, Vietnamese</i> <input type="checkbox"/> Pacific Islander

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**Additional patient medical information:**

Is relative affected with symptoms?  Yes  No

If Yes, please describe:

Relevant family history:

**\*\*PHOTOCOPY REQUISITION AND INCLUDE 1 COPY WITH SAMPLES\*\***