WHOLE EXOME SEQUENCING REQUISITION
PROBAND

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

Appointment booking can be done at www.lifelabs.com

Schillingallee 68 · 18057 Rostock Germany

CONTRACT #	**LL: K012-01**	**LifeLabs Demographic Label**
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:	**Confirmation of patient consent:** 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.	**Additional Label** (if needed)
Copy to: ❑ Genetic Counsellor ❑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:** ❑ Female ❑ 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:	❑ **Genetic Test - Blood Sample** 2 x 4mL EDTA	**4005**	**ACG**
	❑ **Genetic Test (Pediatric) - Blood Sample** 1 x 2mL EDTA	**4008**	**CEN**
	❑ **Genetic Test – DNA** (1-10ug)	**4014**	**OCG**
	❑ **Genetic Test – Filter card** (available by request)	**4014**	**OCG**
	❑ **Genetic Test – Other:** _____	**4014**	**OCG**
	***PRENATAL SAMPLES**: Please ship directly to CENTOGENE*		

Date Sample Collected:	M M D D Y Y Y Y	**Time Collected:**	H H M M	**Collector Name:**	

Test Selection:

Sequencing – select ONE of the following options:

☐ **Centoxome Gold**
70-100x average coverage (~95% targeted bases covered >10X) ▪ Turnaround time <55 working days ▪ No prenatal testing available

☐ **Centoxome Platinum**
100-130x average coverage (~95% targeted bases covered >20X) ▪ Turnaround time <15 working days ▪ Prenatal testing available

Number of samples – select ONE of the following options:

☐ **Solo**
Solo implies analysis of index patient only; we recommend Trio analysis for enhanced diagnostic accuracy.

☐ **Trio**
Trio implies analysis of index patient along with the parents.

☐ **Trio Plus**
"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.

Sequence analysis data exchange: □ **fastq files** □ **bam files** □ **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.

□ **Data selected above with annotated and filtered variant report** - filtered variant report as Excel table

Ordering checklist

Each of these are mandatory for Whole Exome Sequencing

□ **Proband requisition**
□ **Clinical Features checklist completed (bottom of page 2)**
□ **Informed consent**
□ **Parental 1 requisition** *(if Trio selected)*
□ **Parental 2 requisitions** *(if Trio selected)*
□ **Additional Family Member requisitions** *(if TrioPlus selected OR Parental samples unavailable)*

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

WHOLE EXOME SEQUENCING REQUISITION
PROBAND

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

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

CLINICAL FEATURES CHECKLIST

Cardiovascular
- ☐ Angioedema
- ☐ Aortic dilatation
- ☐ Arrhythmia
- ☐ Coarctation of aorta
- ☐ Defect of atrial septum
- ☐ Defect of ventral septum
- ☐ Dil. Cardiomyopathy
- ☐ Hypertension
- ☐ Hypertroph. Cardiomyopathy
- ☐ Hypotension
- ☐ Long QT syndrome
- ☐ Lymphedema
- ☐ Malf. of heart and great vessels
- ☐ Myocardial infarction
- ☐ Stroke
- ☐ Tetralogy of Fallot
- ☐ Vasculitis/angiitis

Mouth, Throat, and Ear
- ☐ Abnormality of dental color
- ☐ Cleft lip/palate
- ☐ Ear malformation
- ☐ Hearing impairment
- ☐ Hypodontia

Neurological
- ☐ Abnormal myelation
- ☐ Ataxia
- ☐ Attention deficit disorder
- ☐ Autism
- ☐ Brain atrophy
- ☐ Cerebral hypoplasia
- ☐ Chorea
- ☐ Corpus callosum agenesis
- ☐ Cortical dysplasia
- ☐ Craniosynostosis
- ☐ Delayed motor milestones
- ☐ Delayed speech
- ☐ Dementia
- ☐ Development regression
- ☐ Dystonia
- ☐ Encephalopathy
- ☐ Epilepsy, febrile
- ☐ Epilepsy, focal
- ☐ Epilepsy, generalized
- ☐ Headache/Migraine
- ☐ Heteropia
- ☐ Holoprosencephaly
- ☐ Hydrocephalus
- ☐ Hyperflexia
- ☐ Intellectual disability
- ☐ Leukodystrophy
- ☐ Lissencephaly
- ☐ Macrocephaly
- ☐ Muscular hypertonia
- ☐ Muscular hypotonia
- ☐ Neuropathy
- ☐ Parkinson
- ☐ Psychiatric syndromes
- ☐ Spasticity
- ☐ Stroke

Reproductive disorders
- ☐ Abn. external genitalia
- ☐ Abnormal internal genitalia
- ☐ Hypogonadism
- ☐ Hypospadias
- ☐ Infertility

Ophthalmological
- ☐ Blepharospasm
- ☐ Cataract
- ☐ Coloboma
- ☐ Glaucoma
- ☐ Microphthalmos
- ☐ Nystagmus
- ☐ Ophthalmoplegia
- ☐ Optic atrophy
- ☐ Ptosis
- ☐ Retinitis pigmentosa
- ☐ Retinoblastoma
- ☐ Strabismus
- ☐ Vision loss

Bone, Skin and immune
- ☐ Abnormal hair
- ☐ Abnormal nails
- ☐ Abnormal pigmentation
- ☐ Anemia
- ☐ Club foot
- ☐ Dysmorphic features
- ☐ Hyperextensible skin
- ☐ Ichthyosis
- ☐ Ichthyosis
- ☐ Joint contractures
- ☐ Joint hypermobility
- ☐ Limp malformation
- ☐ Pancytopenia
- ☐ Polydactyly
- ☐ Scoliosis
- ☐ Skeletal abnormalities
- ☐ Skin tumors
- ☐ Syndactyly
- ☐ Talipes equinovarus
- ☐ Vertebral anomaly

Metabolic
- ☐ Abnormal creatine kinase
- ☐ CSF lactate increase
- ☐ Decreased plasma carnitine
- ☐ Elevated alanine
- ☐ Elevated pyruvate
- ☐ Hypoglycemia
- ☐ Ketosis
- ☐ Lactic academia
- ☐ Organic aciduria

Liver/Kidney/ Endocrinology/Gastrointestinal
- ☐ Abnormal renal morphology
- ☐ Abnormal urinary system
- ☐ Aganglionic megacolon
- ☐ Constipation
- ☐ Diabetes mellitus
- ☐ Diarrhea
- ☐ Elevated transaminases
- ☐ Gastroschisis
- ☐ Hepatic failure
- ☐ Hepatomegaly
- ☐ Hydronephrosis
- ☐ Hyper/hypothyroidism
- ☐ Hypo/hyperparathyroidism
- ☐ Hypoparathyroidism
- ☐ Obesity
- ☐ Paraganglioma
- ☐ Pheochromocytoma
- ☐ Pyloric stenosis
- ☐ Recurrent vomiting
- ☐ Renal agenesis
- ☐ Renal cyst
- ☐ Renal tubulopathy

Tumoral and haematological
- ☐ Abnormal hemoglobin
- ☐ Adenomatous polyposis
- ☐ Brain tumor
- ☐ Breast cancer
- ☐ Coagulation disorder
- ☐ Colorectal tumor
- ☐ Immunodeficiency
- ☐ Leukemia
- ☐ Lung tumor
- ☐ Melanoma
- ☐ Myelofibrosis
- ☐ Neutropenia
- ☐ Pancytopenia
- ☐ Splenomegaly
- ☐ Thrombocytopenia

Prenatal and Development
- ☐ Hemihypertrophy
- ☐ Hydrops fetalis
- ☐ Oligohydramnios
- ☐ Failure to thrive
- ☐ Intrauterine growth restriction
- ☐ Overgrowth
- ☐ Polyhydramnios
- ☐ Premature birth
- ☐ Short Stature
- ☐ Tall Stature

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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 materia**l 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.

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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 for 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: _____

WHOLE EXOME SEQUENCING REQUISITION
PARENTAL 1

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CONTRACT #	**LL: K012-01 / BC: no contract#**	**LifeLabs Demographic Label**
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:	**Additional LifeLabs Label** (if needed)
Physician Signature:		

Copy to :	Copy to name Tel: Fax:	❑ Genetic Counsellor ❑ Other Healthcare Provider
Bill to:	**Contract # K012-01** (patient does not pay at time of collection)	
Provincial Healthcard #:		**Patient Sex:** ❑ Female ❑ Male

Patient Last Name:	**Patient First Name:**	**Patient DOB:**
		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

Sample Type:		**ON-LL TR#**	**Mnemonic**
	❑ **Genetic Test - Blood Sample** 2 x 4mL EDTA	**4005**	**ACG**
	❑ **Genetic Test (Pediatric) - Blood Sample** 1 x 2mL EDTA	**4008**	**CEN**
	❑ **Genetic Test – DNA** (1-10ug)	**4014**	**OCG**
	❑ **Genetic Test – Filter card** (available by request)	**4014**	**OCG**
	❑ **Genetic Test – Other:** _____	**4014**	**OCG**
	***PRENATAL SAMPLES**: Please ship directly to CENTOGENE*		

Date Sample Collected:	M M D D Y Y Y Y	**Time Collected:**	H H M M	**Collector Name:**	

CENTOXOME® PARENTALS
(must accompany "Whole Exome Sequencing – Proband")

Proband Name:		
Parental Information:	❑ African ❑ Caucasian ❑ French Canadian or Cajun ❑ Middle Eastern ❑ Northern European *e.g. British, German* ❑ South Asian *e.g. Indian, Pakistani* ❑ East Asian *e.g. Chinese, Japanese*	❑ Ashkenazi Jewish ❑ Other/Mixed Caucasian ❑ Native American ❑ Hispanic ❑ Southern European *e.g. Italian, Greek* ❑ Southeast Asian *e.g. Filipino, Vietnamese* ❑ Pacific Islander
	Additional patient medical information: **Is relative affected with symptoms?** ❑ Yes ❑ No **If Yes, please describe:** **Relevant family history:**	

WHOLE EXOME SEQUENCING REQUISITION
PARENTAL 2

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

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CONTRACT #	**LL: K012-01 / BC: no contract#**	**LifeLabs Demographic Label**
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:	**Additional LifeLabs Label** (if needed)
Physician Signature:		
Copy to :	Copy to name Tel: Fax:	❑ Genetic Counsellor ❑ Other Healthcare Provider
Bill to:	**Contract # K012-01** (patient does not pay at time of collection)	
Provincial Healthcard #:		**Patient Sex:** ❑ Female ❑ Male

Patient Last Name:	**Patient First Name:**	**Patient DOB:**
		M M D D Y Y Y Y

Unit #:	**Street:**	**City:**	**Prov.:**	**Postal Code:**	**Patient Telephone #:**
					( ) -

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TEST REQUESTED

Sample Type:		**ON-LL TR#**	**Mnemonic**
	❑ **Genetic Test - Blood Sample** 2 x 4mL EDTA	**4005**	**ACG**
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	PRENATAL SAMPLES: *Please ship directly to CENTOGENE*		

Date Sample Collected:	M M D D Y Y Y Y	**Time Collected:**	H H M M	**Collector Name:**	

CENTOXOME® PARENTALS
(must accompany "Whole Exome Sequencing – Proband")

Proband Name:		
Parental Information:	❑ African ❑ Caucasian ❑ French Canadian or Cajun ❑ Middle Eastern ❑ Northern European *e.g. British, German* ❑ South Asian *e.g. Indian, Pakistani* ❑ East Asian *e.g. Chinese, Japanese*	❑ Ashkenazi Jewish ❑ Other/Mixed Caucasian ❑ Native American ❑ Hispanic ❑ Southern European *e.g. Italian, Greek* ❑ Southeast Asian *e.g. Filipino, Vietnamese* ❑ Pacific Islander
	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****

WHOLE EXOME SEQUENCING REQUISITION
Additional Family Members

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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:	**Additional LifeLabs Label** (if needed)
Physician Signature:		
Copy to :	Copy to name Tel: Fax:	❑ Genetic Counsellor ❑ Other Healthcare Provider
Bill to:	**Contract # K012-01** (patient does not pay at time of collection)	
Provincial Healthcard #:		**Patient Sex:** ❑ Female ❑ Male

Patient Last Name:	**Patient First Name:**	**Patient DOB:**
		M M D D Y Y Y Y

Unit #:	**Street:**	**City:**	**Prov.:**	**Postal Code:**	**Patient Telephone #:**
					( ) -

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TEST REQUESTED

Sample Type:		**ON-LL TR#**	**Mnemonic**
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	***PRENATAL SAMPLES**: Please ship directly to CENTOGENE*		

Date Sample Collected:	M M	D D	Y Y Y Y	**Time Collected:**	H H M M	**Collector Name:**	

CENTOXOME® PARENTALS
(must accompany "Whole Exome Sequencing – Proband")

Proband Name:		
Parental Information:	❑ African ❑ Caucasian ❑ French Canadian or Cajun ❑ Middle Eastern ❑ Northern European *e.g. British, German* ❑ South Asian *e.g. Indian, Pakistani* ❑ East Asian *e.g. Chinese, Japanese*	❑ Ashkenazi Jewish ❑ Other/Mixed Caucasian ❑ Native American ❑ Hispanic ❑ Southern European *e.g. Italian, Greek* ❑ Southeast Asian *e.g. Filipino, Vietnamese* ❑ 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****

CENTOGENE WHOLE EXOME
Private Payment Authorization Form

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

Appointment booking can be done at www.lifelabs.com

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For private pay samples, please complete send this credit card payment form along with the laboratory requisition and sample to:

LifeLabs • Attn SPECIMEN MANAGEMENT Department • 37 Voyager Court N.• Toronto ON• M9W 6J2

Test selected:

- ☐ Whole Exome Sequencing Solo – Gold **$ 1500.00**
- ☐ Whole Exome Sequencing Trio – Gold **$ 3500.00**
- ☐ Whole Exome Sequencing Trio – Platinum **$ 6000.00**

Please print:

Last Name:	First Name:	Initial
Birth Date: (dd/mm/yyyy)	Phone Number:	
E-mail:		
Address:		
City:	Province:	Postal Code:

☐ Yes, please mail me a copy of my receipt to the above address

PAYMENT

☐ Visa ☐ Mastercard

CREDIT CARD NUMBER

EXP. DATE (MM/YY)

TOTAL AMOUNT

$ _____ CDN

I understand that my credit card will be charged for the full amount of testing.

CVC CODE

CREDIT CARD HOLDER

SIGNATURE

DATE