LifeLabs GENETICS™

GENETIC TESTING REQUISITION

CENTOGENE
THE RARE DISEASE COMPANY

1-844-363-4357 · Ask.Genetics@LifeLabs.com Appointment booking: 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

	ON-LL TR#	Mneumonic
❑ **Genetic Test - Blood Sample** 2 x 4mL EDTA	**4005**	**ACG**
❑ **Genetic Test (Pediatric) - Blood Sample** 1 x 2mL EDTA	**4008**	**CEN**
❑ **Genetic Test - Other Sample Type**	**4014**	**OCG**

PRENATAL SAMPLES: *Please ship directly to CENTOGENE, contact us in advance*

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

GENETIC TESTING CONSENT

I understand that my specimen for DNA analysis will be sent to LifeLabs for genetic testing. My physician has told me about the condition(s) being tested and its genetic basis. 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 ensure 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.

1. I understand that once the requested test(s) has/have been completed, any remaining sample will be stored at the testing laboratory.
2. I agree that my de-identified sample may be used for product development or research purposes. I understand that I will not receive any royalties, resultant payments, benefits or rights to products or discoveries.

❑ 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 and 2 listed above.

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:** ____________________

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

both pages are mandatory

The minimum amount of patient information is collected for provision of the service requested. This information is considered confidential. Unauthorized use and disclosure are prohibited.

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

Testing Instructions: Please use the online catalogue to find test code & names: **www.lifelabsgenetics.com /hereditary-conditions**	**Test Code(s):** ______ **Test Name(s):** ______ **Test methodology** ❑ FULL ANALYSIS *(includes sequencing AND deletion/duplication analysis if available AND repeat expansion if available)* ❑ Sequencing ❑ Deletion/Duplication analysis ❑ Repeat Expansion ❑ Other - *please specify:* **Special Instructions** (reflex order): ❑ Familial Mutation (*Familial Report attached* **Y/N**) *Gene:*______ *Mutation (HGVS):*______
Sample Type:	❑ ***Blood** (EDTA: 5mL for single gene, 10mL for panel) ❑ ***Filter card** (1 card/30 exons, available by request) ❑ **DNA** (single gene:1-10ug, panel 10-100ug) ❑ **Saliva** (Oragene OG-510, available by request) ❑ **Fibroblast/Skin Biopsy** (0.5cm²) * Exact amount depends on size of panel, contact LifeLabs Genetics ❑ **Cultured cells** (1 flask, min 25cm², 80-90% confluent) ❑ ****Amniotic fluid** (10mL) ❑ ****Chorionic Villus** (10 villi, cleaned) ❑ ****FFPE** (20-50 mg) ❑ **Other:** ______ ** Must contact LifeLabs Genetics prior to sending sample
Patient 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 ❑ Indigenous ❑ Hispanic ❑ Southern European e.g. *Italian, Greek* ❑ Southeast Asian e.g. *Filipino, Vietnamese* ❑ Pacific Islander ❑ Other – *please specify:* ______
	Additional patient medical information: **Relevant family history:**
	Have other family members submitted samples to LifeLabs/Centogene for analysis? ❑Y ❑ N If yes, Name:______ Relationship to patient ______ DOB *(DD/MM/YYY)*:______
Billing Status:	❑ **Provincial Funding Approved** *(Approval letter attached)* ❑ **Provinincial Funding Approval Pending** ❑ **Private Pay** *(Complete information below)* ❑ **Institution** *(Complete information below)*
Institution Billing ONLY:	**Institution Name:** ______ **Contact Name:** ______ **Address:** **Phone:** ( ) - **Fax:** ( ) - **Email:** ______
Private Pay ONLY:	**Credit Card Type:** ❑ **MasterCard** ❑ **Visa** **Card Number**______ **Exp Date(MM/YY)**______ **Name (as it appears on credit card)**______ **I understand that my credit card will be charged for the full amount of testing not paid for by my provincial health plan** **Cardholder Signature:** ______ **Date (DD/MM/YYYY)**______

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