PRAXIS GENOMICS

All testing requests must be submitted by a qualified Healthcare Provider

THIS FORM MUST ACCOMPANY ALL SAMPLES

LAB USE ONLY

6115 Peachtree Dunwoody Rd, Suite 220 | Atlanta, GA 30328 | Phone: 678-837-4022 | Testing information available at www.praxisgenomics.com

CARRIER TEST REQUEST FORM

Patient Information

Last (Family) Name	First Name	MI	Date of Birth
			____/____/____ MONTH DAY YEAR

Patient ID / Medical Record Number	Specimen Collection Date / Shipping Condition	Sex
	____/____/____ MONTH DAY YEAR ☐ Room Temperature ☐ Frozen	☐ Male ☐ Female

Has Patient been previously tested at this facility?

☐ No ☐ Yes, Lab ID# :_____

Has a Relative been previously tested at this facility?

☐ No ☐ Yes, Lab ID# :_____

Name:_____

DOB : ____/____/____ MONTH DAY YEAR

Relation to patient: _____

Specimen Source

- ☐ Whole Blood*
- ☐ Cultured Cells*, Type _____
- ☐ Tissue*, Type _____
- ☐ Saliva
- ☐ Buccal Swab
- ☐ Extracted DNA

*Only Whole Blood, Cells or Tissue are acceptable for OGM and Transcriptome testing. Blood samples for Transcriptome testing must be frozen or stabilized in Tempus tubes. See website for details.

Reason for Test

- ☐ Diagnosis / Affected
- ☐ Presymptomatic / At Risk
- ☐ Carrier Testing / Unaffected

ICD-10 Diagnosis Codes

1:_____ 2:_____
3:_____ 4:_____
5:_____ 6:_____
7:_____ 8:_____

Blood Transfusion / Marrow Transplant

- ☐ No
- ☐ Within Last 30 Days, Date and Type

____/____/____ MONTH DAY YEAR Type: _____

Provide Clinical Information on Page 3. Only Biological Parentage information is relevant. Maternal Cell Contamination (MCC) Reports are required for all fetal samples. See the test description for details. Standard Test turnaround time is four weeks. STAT Testing is two weeks. All Duo/Couple and Trio testing requires the Additional Family Members subsection on Page 2 to be filled out.

Test Selection

Optical Genome Mapping (OGM)
- ☐ (OGM005) Carrier Single
- ☐ (OGM006) Carrier Duo

Whole Genome Sequencing (WGS)
- ☐ (SRG005) Carrier Single
- ☐ (SRG006) Carrier Duo

Combined OGM & WGS
- ☐ (PRX005) Carrier Single
- ☐ (PRX006) Carrier Duo

☐ **STAT Testing (add-on)**
Not available for single patient tests

Submitting Provider Information

Institution	Invoice ID

Address	City	State	ZIP

Requesting Physician (First, Last, Degree)	Requesting Genetic Counselor or Provider (First, Last, Degree)

Primary Email Address for Report Delivery	Secondary Email Address for Report Delivery

Phone Number	NPI#	Phone Number	NPI#

Email Address for Invoice Delivery

Billing Information Notice

Payment for testing is handled through an invoice system. The invoice is generated following consultation about the appropriate test to be ordered. Please Include the unique Invoice ID in the **Submitting Provider Information** section above. The invoice must be paid in full before samples are processed by Praxis Genomics. Samples received with incorrect or missing invoice information will be delayed or possibly rejected depending on sample collection date. For payment options visit our website at: www.praxisgenomics.com/billing or contact us at 678-837-4022 or support@praxisgenomics.com.

Additional Family Members

Partner Information

Last (Family) Name	First Name	MI	Date of Birth
			_____ /_____ /_____ MONTH DAY YEAR

Patient ID / Medical Record Number	Specimen Collection Date / Shipping Condition	Sex
	_____ /_____ /_____ MONTH DAY YEAR ☐ Room Temperature ☐ Frozen	☐ Male ☐ Female

Has Patient been previously tested at this facility?	Specimen Source	Diagnosis	ICD-10 Diagnosis Codes
☐ No ☐ Yes, Lab ID# :_____	☐ Whole Blood ☐ Cultured Cells, Source _____ ☐ Tissue, Source _____ ☐ Extracted DNA, Source _____ ☐ CVS ☐ Direct Amniotic Fluid	☐ Affected ☐ Unaffected ☐ Unknown	1:_____2:_____ 3:_____4:_____ 5:_____6:_____ 7:_____8:_____
Relationship to Proband	**NOTE:** Currently all production testing provided requires Whole blood or Cultured Cells. Praxis Genomics only accepts other sample types for testing for mutually approved research purposes.	Blood Transfusion / Marrow Transplant ☐ No ☐ Within Last 30 Days, Date and Type _____ /_____ /_____ MONTH DAY YEAR Type: _____	

Clinical Information - Please fill out separate sheet for each individual

Behavioral/Psychiatric
- ☐ Anxiety
- ☐ Attention Deficit Hyperactivity Disorder
- ☐ Autism
- ☐ Behavioral/Psychiatric Abnormality
- ☐ Dementia
- ☐ Pervasive Developmental Delay

Cardiac
- ☐ Aortic Atresia
- ☐ ASD
- ☐ Atrial Septal Defect
- ☐ AV Canal Defect
- ☐ Coarctation of the Aorta
- ☐ Congestive Heart Failure
- ☐ Dextrocardia and Situs Inversus
- ☐ Double Outlet Right Ventricle
- ☐ Ebstein's Anomaly
- ☐ Echogenic Intracardiac Focus
- ☐ Hypoplastic Left Heart
- ☐ Pulmonary Valve Atresia
- ☐ Tetralogy of Fallot
- ☐ Transposition of the Great Vessels
- ☐ Truncus Arteriosus
- ☐ Ventricular Septal Defect

Cognitive/Developmental
- ☐ Developmental Delay
- ☐ Fine Motor Delay
- ☐ Gross Motor Delay
- ☐ Intellectual Disability/MR
- ☐ Learning Disability
- ☐ Speech Delay

Craniofacial
- ☐ Cleft Lip +/- Cleft Palate
- ☐ Dysmorphic Facial Features
- ☐ Ear Malformation
- ☐ Hyper/Hypotelorism
- ☐ Macrocephaly
- ☐ Microcephaly

Cutaneous
- ☐ Acne
- ☐ Alopecia
- ☐ Axillary/Inguinal Freckling
- ☐ Blisters
- ☐ Café-Au-Lait Spots
- ☐ Congenital Nevus
- ☐ Ectodermal Dysplasia
- ☐ Ichthyosis
- ☐ Loose Skin
- ☐ Papules
- ☐ Psoriasis
- ☐ Striae
- ☐ Urticaria

Endocrine/Exocrine
- ☐ Adrenal
- ☐ Bone
- ☐ Diabetes Mellitus
- ☐ Hypothalamus
- ☐ Pancreas
- ☐ Parathyroid
- ☐ Pituitary
- ☐ Reproductive
- ☐ Thyroid

Gastrointestinal
- ☐ Absent Stomach
- ☐ Echogenic Focus
- ☐ Gastrointestinal Pseudo Obstruction
- ☐ Gastroschisis
- ☐ Meconium Ileus / Anal Atresia
- ☐ Omphalocele
- ☐ Pyloric Stenosis
- ☐ Tracheoesophageal Fistula

Genitourinary
- ☐ Ambiguous Genitalia
- ☐ Cryptorchidism
- ☐ Hydronephrosis
- ☐ Hypoparathyroidism
- ☐ Hypospadias
- ☐ Hypothyroidism
- ☐ Kidney Malformation
- ☐ Megacystis (incl. posterior valves)
- ☐ Myoglobinuria
- ☐ Polycystic Kidneys
- ☐ Renal Agenesis
- ☐ Urethra/Ureter Obstruction

Growth
- ☐ Failure to Thrive
- ☐ Overgrowth
- ☐ Short Stature

Hearing/Vision
- ☐ Abnormality of Eye Movement
- ☐ Abnormality of Vision
- ☐ Hearing Loss
- ☐ Migraine Headache
- ☐ Optic Atrophy
- ☐ Ptosis
- ☐ Retinopathy

Hematology
- ☐ Anemia
- ☐ Clotting Disorder
- ☐ Hemophilia
- ☐ Neutropenia
- ☐ Thrombocytopenia

Immune System
- ☐ Autoimmune Disorders
- ☐ Immunodeficiency

Metabolic/Laboratory Abnormalities
- ☐ Biliary Tract
- ☐ Blood Gases
- ☐ Electrolytes
- ☐ Gastrointestinal
- ☐ Glycoproteins
- ☐ Kidney
- ☐ Lipids
- ☐ Liver
- ☐ Mitochondrial

Musculoskeletal
- ☐ Acromelia
- ☐ Clenched Hands
- ☐ Club Foot (bilateral)
- ☐ Contractures (arthrogryposis)
- ☐ Cramps After Exercise
- ☐ Diaphragmatic Hernia
- ☐ Exercise Intolerance
- ☐ Joint Laxity
- ☐ Limb Anomaly
- ☐ Mesomelia
- ☐ Micromelia
- ☐ Myoclonus
- ☐ Ophthalmoplegia
- ☐ Polydactyly
- ☐ Proximal Limb Weakness
- ☐ Scoliosis
- ☐ Skeletal Dysplasia
- ☐ Syndactyly
- ☐ Vertebral Anomaly

Neoplasia
- ☐ Bone and Joints
- ☐ Breast
- ☐ Cancer Syndromes
- ☐ CNS
- ☐ Endocrine
- ☐ GI
- ☐ GU
- ☐ Hamartoma
- ☐ Head and Neck
- ☐ Hematopoietic / Lymphatic
- ☐ Intrathoracic Malignancies
- ☐ Neurofibroma
- ☐ Optic Gliomas
- ☐ Skin
- ☐ Soft Tissue

Neurological
- ☐ Abnormal Gyri (Lissencephaly)
- ☐ Agenesis of the Corpus Callosum
- ☐ Asthenia
- ☐ Cerebellar Hypoplasia
- ☐ Cerebellar Signs
- ☐ Cerebral Blindness
- ☐ Cerebral Palsy
- ☐ Dandy Walker (posterior fossa abnormality)
- ☐ Encephalopathy
- ☐ Headache
- ☐ Holoproscencephaly
- ☐ Hypertonia
- ☐ Hypotonia
- ☐ Macrocephaly
- ☐ Microcephaly
- ☐ Neural Tube Defect
- ☐ Neuropathy
- ☐ Seizures
- ☐ Stroke
- ☐ Structural Brain Anomaly
- ☐ Ventriculomegaly/Hydrocephaly

Prenatal/Perinatal History
- ☐ 2 Vessel Cord
- ☐ Decreased Fetal Movement
- ☐ Echogenic Focus
- ☐ Floppy Baby
- ☐ Increased Nuchal Translucency
- ☐ IUGR
- ☐ Non-Immune Hydrops Fetalis
- ☐ Oligohydraminos
- ☐ Perinatal Insult
- ☐ Polyhydramnios
- ☐ Prematurity

Pulmonary
- ☐ CCAM/Small Thoracic Cavity
- ☐ Diaphragmatic Hernia
- ☐ Eventration of Diaphragm
- ☐ Pleural Effusion
- ☐ Pulmonary Sequestration
- ☐ Respiratory Insufficiency

Pedigrees may be attached or illustrated on the back of this page. Detail any findings of chromosomal abnormalities in the comments below. Prior pregnancy risk, multiple gestation evidence and maternal age/weight must be disclosed below if applicable.

Labs (describe findings)	Family History / Ethnicity / IVF Details	Additional Comments
Imaging (describe findings)		
	Prior Genetic Testing	
Electrophysiology (describe findings)		

Please attach any additional sheets or information you think is pertinent to the patient's condition.