BCM-MEDICAL GENETICS LABORATORIES
WHOLE GENOME LABORATORY

PHONE: 1-877-798-1063| FAX: 713-798-2787 | www.cancergeneticslab.org

SHIP TO: Cancer Genetics Laboratory
Baylor College of Medicine
2450 Holcombe, Grand Blvd. -Receiving Dock
Houston, TX 77021-2024
Phone: 713-798-6555

BASIC3 GERMLINE SEQUENCING FORM

PATIENT INFORMATION

NAME: _____ (LAST NAME) _____ (FIRST NAME) ___ (MI)

DATE OF BIRTH: ___ / ___ / ___ (MM / DD / YY)

GENDER (Please select one): ☐ FEMALE ☐ MALE ☐ UNKNOWN

MEDICAL RECORD #: _____

ACCESSION #: _____

HOSPITAL #: _____

CONSENT DATE: _____

STUDY #: _____

ETHNIC BACKGROUND (Select all that apply):

☐ AFRICAN AMERICAN
☐ ASIAN
☐ ASHKENAZIC JEWISH
☐ EUROPEAN CAUCASIAN
☐ HISPANIC
☐ NATIVE AMERICAN INDIAN
☐ OTHER JEWISH
☐ OTHER (Please specify): _____

REPORTING INFORMATION

*BCM-MEDICAL GENETICS LABORATORIES HAS A FAX ONLY POLICY FOR REPORTING

PHYSICIAN: Sharon Plon, M.D., Ph.D.

INSTITUTION: TCH

PHONE: 832-824-4251 *FAX: 832-825-4276

ADDITIONAL PROFESSIONAL REPORT RECIPIENTS

NAME: _____

PHONE: _____ *FAX: _____

NAME: BASIC3 Germline Group

PHONE: _____ *FAX: 832-825-4276

SAMPLE INFORMATION

☐ PERIPHERAL BLOOD (AS DNA SOURCE)

DATE OF COLLECTION: ___ / ___ / ___ (MM / DD / YY) TIME OF COLLECTION: _____

TESTS REQUESTED

Tumor Sample Available for Sequencing:

☐ YES -- **9601 & 1590**

☐ NO -- **1591**

INSTITUTIONAL BILLING INFORMATION

INSTITUTION NAME: BASIC3 Study

INSTITUTION CODE: BTPL

FAMILY HISTORY

Family History of Cancer: ☐ YES ☐ NO

If yes, please provide detailed information on affected family members and/or a pedigree.

LAST UPDATED: 4/14/2014

BCM-MEDICAL GENETICS LABORATORIES
WHOLE GENOME LABORATORY

PHONE: 1-877-798-1063| FAX: 713-798-2787 | www.cancergeneticslab.org

SHIP TO: Cancer Genetics Laboratory
Baylor College of Medicine
2450 Holcombe, Grand Blvd. -Receiving Dock
Houston, TX 77021-2024
Phone: 713-798-6555

BASIC3 GERMLINE SEQUENCING FORM

NAME: _____ (LAST NAME) _____ (FIRST NAME) ___ (MI) DATE OF BIRTH: ___ / ___ / ___ (MM / DD / YY) GENDER (Please select one): ☐ FEMALE ☐ MALE ☐ UNKNOWN

Please provide the following clinical information regarding the patient to be tested. If answering "yes," please provide additional description as appropriate (e.g., percentiles for growth parameters, type of limb abnormality, etc.). Please also submit a clinic note and pedigree if available. This information is needed to facilitate interpretation of whole exome sequencing results. If the laboratory requires additional information, please indicate the health care provider to be contacted:

NAME: Sharon Plon PHONE/PAGER #: 832-824-4251; pager# 4420

	PATIENT DESCRIPTION		NO	UNKNOWN
Prematurity	☐		☐	☐
Intrauterine growth restriction	☐		☐	☐
Delayed motor milestones	☐		☐	☐
Delayed speech	☐		☐	☐
Developmental regression	☐		☐	☐
Autism/Autistic spectrum	☐		☐	☐
Intellectual disability	☐		☐	☐
Hearing loss	☐		☐	☐
Hypotonia	☐		☐	☐
Hypertonia/Spasticity	☐		☐	☐
Seizure disorder	☐		☐	☐
Ataxia	☐		☐	☐
Abnormal movements	☐		☐	☐
Dysmorphic features	☐		☐	☐
Short stature	☐		☐	☐
Tall habitus	☐		☐	☐
Microcephaly	☐		☐	☐
Macrocephaly	☐		☐	☐
Hyperextensibility	☐		☐	☐
Joint contractures	☐		☐	☐
Obesity/Overgrowth	☐		☐	☐
Failure to thrive	☐		☐	☐
Structural brain abnormalities	☐		☐	☐
Eye anomalies	☐		☐	☐
Vision loss	☐		☐	☐

LAST UPDATED: 4/14/2014

BCM-MEDICAL GENETICS LABORATORIES
WHOLE GENOME LABORATORY

PHONE: 1-877-798-1063| FAX: 713-798-2787 | www.cancergeneticslab.org

SHIP TO: Cancer Genetics Laboratory
Baylor College of Medicine
2450 Holcombe, Grand Blvd. -Receiving Dock
Houston, TX 77021-2024
Phone: 713-798-6555

BASIC3 GERMLINE SEQUENCING FORM

NAME: _____ (LAST NAME) _____ (FIRST NAME) ___ (MI) DATE OF BIRTH: ___ / ___ / ___ (MM / DD / YY) GENDER (Please select one): ☐ FEMALE ☐ MALE ☐ UNKNOWN

	PATIENT DESCRIPTION		NO	UNKNOWN
Congenital heart disease	☐		☐	☐
Kidney abnormalities	☐		☐	☐
Skeletal abnormalities	☐		☐	☐
Scoliosis	☐		☐	☐
Limb malformation	☐		☐	☐
Skin anomalies	☐		☐	☐
Genital anomalies	☐		☐	☐
Organomegaly	☐		☐	☐
Hemihypertrophy	☐		☐	☐
Cancer/tumor formation	☐		☐	☐
Family history of non-cancer disorder	☐		☐	☐

Please read the below statements carefully and check the appropriate box and initial. Please note that if neither box is checked the lab will default to the YES/ reporting option.

Initial

Carrier Status for Autosomal Recessive Conditions

_____ ☐ YES, please report carrier status. By checking this box, I choose to receive information regarding carrier status.

_____ ☐ NO, please do NOT report carrier status. By checking this box, I choose to NOT receive information regarding carrier status.

LAST UPDATED: 4/14/2014