Revive Genetics Diagnostics Laboratory

CLIA: 10D2337214

Whole Genome Testing Panel

Requisition & Consent Form

Patient Information

Last Name	First Name	DOB	Sex	MRN

Address	City	State	Zip	Phone Number

Email

Ethnicity ☐ African American ☐ Ashkenazi Jewish ☐ East Asian ☐ Hispanic ☐ Middle Eastern ☐ White ☐ Other

Insurance/Billing Information

Insurance Name	Member ID	Group ID

Primary Name	Primary DOB	Relationship
		☐ Self ☐ Spouse ☐ Child

Ordering Provider/ Facility

Provider Name	NPI	Facility Name	Email

Address	City	State	Zip	Phone Number

Specimen Information

Specimen Type

Collector Name	Collection Date/ Time	Collection Site
		☐ Office ☐ Lab ☐ Home ☐ Other

Confirmation of Medical Necessity for Genetic Testing:

My signature below certifies that I am a licensed medical professional or his/her representative or a genetic counselor authorized to order genetic testing. My signature further acknowledges the patient has been supplied information regarding genetic testing and has been informed about the purpose, limitations, and possible risks. The patient has been given the opportunity to ask questions about this consent and seek outside genetic counseling. The patient has given consent for genetic testing to be performed and the signed consent form is on file. I confirm that this testing is medically necessary for the specified patient, and that these results will be used in the medical management and treatment decisions for this patient. I confirm that the patient has been informed and hereby authorizes (i) Revive Genetics Laboratory to release information concerning their testing to their insurer to obtain reimbursement for the testing services; (ii) Revive Genetics Laboratoryto be paid directly by the insurer for services rendered; and/or if applicable (iii) Revive Genetics Laboratory or its affiliates to be the patient's designated representative for the purpose of appealing any denial of insurance benefits. I confirm the patient fully understands they are legally responsible for sending Revive Genetics Laboratory all the money that they receive directly from their insurance company in payment for this testing.

Medical Professional Signature _____DATE_____

Print Name: _____

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Test Selection

Select	Panel	Genes	Brief Description
	Express Gene™ Clinical Whole Genome Sequencing- Data reanalysis	Genome-wide	Re-evaluation of previously generated whole genome sequencing data using updated clinical information, newly reported gene-disease associations, and current variant interpretation guidelines to identify findings that may not have been recognized during the initial analysis.
	Express Gene™ Clinical Whole Genome Sequencing- Proband Only (Solo)	Genome-wide Solo	Whole genome sequencing performed on the patient alone to evaluate genomic variants associated with suspected genetic conditions and support comprehensive clinical interpretation.
	Express Gene™ Clinical Whole Genome Sequencing- Proband with One Parent (Duo)	Genome-wide Duo	Whole genome sequencing performed on the patient and one biological parent to aid in variant interpretation when one parental sample is available, improving assessment of inheritance and clinical relevance compared with proband-only analysis.
	Express Gene™ Clinical Whole Genome Sequencing- Proband and Both Parents (Trio)	Genome-wide Trio	Whole genome sequencing performed on the patient and both biological parents to improve variant interpretation by assessing inheritance patterns, increasing diagnostic yield, and supporting identification of de novo, recessive, and inherited variants.

Indications for Testing (Check All That Apply)

☐ Diagnostics ☐ Recurrent or Unexplained Infections ☐ Patient Management ☐ Family History

Clinical Information

Genetic Testing Done Previously: ☐ Yes ☐ No	If Yes what test:	Date of Previous Test: ____/____/____

List relevant family history of disease (affected family members and relationship to patient):

Website www.revivegenetics.us Email info@revivegenetics.us	Address 9000 SW 152nd St Suite 107, Palmetto Bay, FL 33157	Lab Director Uzma Farooq, MD	Phone Number 786-250-3419

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Informed Consent:

Consent to Testing and Use of Results: The specimen identified on this form is my own or from my minor child. I have not contaminated it in any way. I am voluntarily submitting this specimen for analysis by my physician and/or Revive Genetics Laboratory. I authorize Revive Genetics Laboratory to release the test results to the ordering practitioner. I further authorize the lab and my healthcare provider to release to my insurance provider any medical information necessary to process the claim.

Consent for Genetic Testing: Your doctor has ordered the Genetics Test for you or your minor child. This is a test for variations in genes that affect your overall health and wellbeing or response to treatment. If variant(s) are present, it may indicate a higher-than-average risk for developing diseases. It will help in evaluating the risk of having or being a carrier of a heritable disease. A lack of the mutation does not completely rule out the disease, since some variations are still unknown, and their significance have not been investigated. Additionally, there is a limitation on NGS sequencing methodology, that certain variation might not being captured or identified with this method. Results from this test(s) are treated with complete confidentiality and reports rendered only to the patient and his/her physician. No tests other than those authorized will be performed and patient samples will be saved for 60 days and then destroyed after testing. I have read this consent or have had it read to me. I have been given a copy of this form. I have been given the chance to ask questions before I sign this form. I have been told that I can ask other questions at any time. I want to have this genetic test done.

Consent / Insurance Release: By signing this form, I hereby authorize Revive Genetics Laboratory to submit the medical information regarding this testing to my designated insurance carrier for reimbursement if necessary. I also authorize benefits to be payable to Revive Genetics Laboratory. I understand that I am responsible for any amounts not paid by insurance for reasons but not limited to non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.

Patient or parent/guardian Signature _____ DATE_____

Print Name: _____

Consent use of sample or data for research: To improve genetic testing results and solve unexplored genetic diseases, I understand and agree that my leftover specimen, genetic data, and/or clinical information may be used anonymously for research, education, and other business purposes. I hereby authorize Revive Genetics Laboratory to contact me in future regarding disease symptoms, recently discovered genes, mutations or to follow up on disease outcomes**. To "opt in" for sample retention, you can sign below, without affecting processing of your tests**.

Patient or parent/guardian Signature _____ DATE_____

Print Name: _____

Medical Professional Signature _____ DATE_____

Print Name: _____