Washington University in St. Louis
School of Medicine

Children's Hospital • St. Louis

REFERRAL FORM FOR WHOLE EXOME SEQUENCING

Child's Name: _____ Date of Birth: _____

Parents/Guardians' Names: _____

Contact Phone Number(s): _____

This form is confidential and will become part of the patient's medical record.

Referring MD:_____ Primary Care Physician: _____
Phone: _____ Phone: _____
Fax: _____ Fax: _____

To refer a patient for whole exome sequencing, please complete the following:

- **Complete this 2 page form in its entirety**
- **Provide printed copies of the patient's pertinent medical records:**
  - **Most recent clinic note from any specialists**
  - **Radiology reports**
  - **Previous laboratory studies (e.g. metabolic and biochemical testing, CSF studies)**
    - **Note: please do not send copies of routine labs such as CBCs and CMPs unless you believe they are relevant to the patient's underlying diagnosis.**
  - **Other diagnostic studies (e.g. EMG, EEG, muscle biopsy, pathology)**
  - **Copies of all previous genetic testing reports**
- **A copy (front and back) of the patient's current insurance card(s)**

Please note that we are unable to schedule the patient for whole exome sequencing until we have received all of the above in addition to this form. These may be faxed to our office at (314) 454-2075, Attn: Genetic Counselors, or delivered to our office by hand or campus mail (Marisa Vineyard, Campus Box 8116).

☐ Please check this box to indicate that you are requesting a consultation for whole exome sequencing for this patient and sign below.

_____ _____
Referring physician signature Date

For Genetics office use only:

- ☐ *Form completed*
- ☐ *Printed records received*
- ☐ *Insurance card*
- ☐ *Reviewed by GC/MD*
- ☐ *Insurance BI submitted*
- ☐ *Insurance approval received*
- ☐ *Family notified of out of pocket*
- ☐ *Applied for financial assistance program*
- ☐ *Appointment scheduled*
- ☐ *Both parents to attend the appt*

Out of pocket amount: $_____

Basic Information

Have you already discussed whole exome sequencing with the family? ☐ Yes ☐ No

Will both biological parents be available to give blood samples? ☐ Yes ☐ No

If not, please explain: _____

If not, does the patient have any full siblings or other family members who might be available to provide a sample? ☐ Yes ☐ No If yes, please list: _____

Clinical Information

Please list your patient's main features and most pertinent clinical history, including a summary of any relevant test results:

_____
_____
_____
_____
_____
_____
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_____

Do you have any specific genetic diagnoses or genes in mind for this patient? ☐ Yes ☐ No

If yes, please list: _____
_____
_____

Prior Genetic Testing – Please provide copies of all genetic test reports

Has the patient had chromosome microarray (CMA)? This is *required* prior to exome sequencing, except in exceptional circumstances.

- ☐ Yes, and the results were normal. Please list the year CMA was performed: _____
- ☐ Yes, but the findings did not explain the patient's phenotype.
- ☐ No, I do not feel it is indicated. Please state reason: _____
- ☐ No, the patient's insurance would not cover CMA.

For each genetic test below, please check the box if the test was completed and list the results, if abnormal.

Test	Abnormal results, including variants of uncertain significance
☐ Karyotype/chromosomes	_____
☐ Fragile X	_____
☐ Epilepsy panel	_____
☐ Prader-Willi/Angelman syndrome	_____
☐ Rett/atypical Rett testing	_____
☐ X-linked intellectual disability panel	_____
☐ Other genetic tests:	_____
	_____
	_____
	_____