Gene Test

Patient Information
Name:
Date of Birth:
Gender:
Family History of Genetic Disorders:
Presenting Symptoms:

Test Requested

- ☐ Single Gene Testing
- ☐ Panel Testing
- ☐ Whole Exome Sequencing
- ☐ Whole Genome Sequencing
- ☐ Other: _____

Purpose of Test

- ☐ Diagnostic
- ☐ Carrier Testing
- ☐ Prenatal Testing
- ☐ Newborn Screening
- ☐ Predictive and Presymptomatic
- ☐ Pharmacogenomics

Sample Collection
Date Collected:
Collected By:

Sample Type:

- ◯ Blood
- ◯ Cheek Swab
- ◯ Amniotic Fluid
- ◯ Other: _____

Laboratory Information

Lab Name:

Lab Address:

Contact Information:

Test Results

Date Reported:

Reported By:

Results:

- ◯ Positive
- ◯ Negative
- ◯ Variant of Unknown Significance (VUS)
- ◯ Inconclusive

Specific Findings:

Interpretation of Results

Genetic Counselor's Name:

Interpretation Date:

Notes:

Recommendations and Follow-Up
Further Testing:
Referral to Specialist:
Family Testing Recommended:
Additional Notes:
Patient Consent
I, _____, hereby consent to the genetic testing as described above.
Signature:
Date:
Physician Signature
Name:
Signature:
Date: