TEST REQUISITION FORM

Whole Exome/Genome & RNA-Sequencing (RISE)

CLIENT NAME/ID (FOR LAB USE): _____

*Mandatory fields

PATIENT INFORMATION

LAST NAME* | FIRST NAME*

SEX ASSIGNED AT BIRTH* | DATE OF BIRTH (MM/DD/YYYY)*

MRN | ETHNICITY

ADDRESS

CITY | STATE | POSTAL CODE | COUNTRY

PHONE | EMAIL

SAMPLE COLLECTION DATE* (MM/DD/YYYY)

SAMPLE TYPE*: ◯ Blood ◯ Buccal/Saliva

◯ Extracted DNA & DNA Source (Blood, Buccal/Saliva, Tissue, Fibroblast): _____ ◯ Other: _____

PATIENT ACKNOWLEDGEMENT

I have read the Informed Consent document and I give permission to Fulgent Genetics and its entities to perform genetic testing as described. I also give permission for my specimen and clinical information to be used in de-identified studies at Fulgent and for publication, if appropriate. My name or other personal identifying information will not be used in or linked to the results of any studies and publications. More information is available at www.fulgentgenetics.com/policies/privacy-policy.

☐ Check this box if you are a New York state resident and give permission for Fulgent to retain any remaining sample longer than 60 days after sample collection.

☐ Opt out of research

X _____ Patient Signature (Required for billing purposes) | Date (MM/DD/YYYY)

ORDERING PROVIDER

INSTITUTION/PRACTICE NAME

INSTITUTION PHONE / FAX | INSTITUTION EMAIL

ORDERING PROVIDER(S)

NPI (USA)/MINC (Canada) | PROVIDER TITLE (MD, DO, GC)

PROVIDER ADDRESS

CITY | STATE | POSTAL CODE | COUNTRY

PROVIDER PHONE | FAX/EMAIL REPORT TO

GC/PRIMARY CONTACT NAME

GC/PRIMARY CONTACT PHONE/FAX | GC/PRIMARY CONTACT EMAIL

STATEMENT OF INFORMED CONSENT

By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

I attest that the patient has received and read the Fulgent Informed Consent document, or has had it read to them, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any Fulgent Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

X _____ Ordering Provider Signature (Required)* | Date (MM/DD/YYYY)*

PATIENT COMMUNICATION CONSENT

☐ By checking this box, you acknowledge and agree that:

a. By executing this agreement, you are providing express written consent for Fulgent, CSI, and Inform Diagnostics, their affiliates and subsidiaries, and parties making contact on their behalf to call and text you using automatic telephone dialing systems and artificial or pre-recorded messages at the telephone number you have provided, about your out-of-pocket estimation, even if your telephone number is currently listed on any state, federal, local or corporate Do Not Call list.

b. Your Consent to be contacted through the use of automatic telephone dialing systems and artificial or pre-recorded messages is not required in order to purchase any property, goods, or services. If you would like to speak with our Benefits Investigation team, you can reach them at **+1 888.FULGENT (+1 888.385.4368), opt 3**.

TEST OPTIONS

Step 1*: Select test(s)

Select only one option from either Whole Exome or FulGenome.

Whole Exome

◯ **Whole Exome Singleton** (FT-TP01873)
◯ **Whole Exome Duo** (FT-TP01958)
◯ **Whole Exome Trio** (FT-TP00246)

FulGenome - Whole Genome Analysis

◯ **FulGenome Singleton** (FT-TP01960)
◯ **FulGenome Duo** (FT-TP01961)
◯ **FulGenome Trio** (FT-TP01871)

For Duo/Trio, is specimen(s) submitted with proband? ◯ **Yes** ◯ **No**

If submitting family member samples, please include them with the proband's sample to avoid delays. Family member samples and information **must be received within 3 weeks** of the proband's sample receipt to be included in the proband's analysis.

Please complete family information on page 2.

☐ **PGx Comprehensive Panel**

☐ Test name or other additional requests

Step 2*: Select Test Option(s)

☐ **Add RISE Analysis**

☐ **Check this box if you wish to receive ACMG secondary findings for the proband**

Step 3*: Include Clinical Indications/Suspected Diagnosis

Clinical information is REQUIRED for testing. Please attach medical records and/or complete Page 3.

Exome/Genome Sequencing is a patient-centric, phenotype-driven analysis designed to report only variants that are of plausible clinical relevance. Please provide relevant clinical history, suspected diagnosis, or family history.

Specimen Requirements:

1 x EDTA tube (required for RISE RNA analysis)
- 4 mL whole blood

Saliva swabs are accepted for DNA only Exome/Genome analysis

TEST REQUISITION FORM

Whole Exome/Genome & RNA-Sequencing (RISE)

FAMILY SAMPLES FOR DUO/TRIO TESTING

COMPLETE THIS SECTION IF FAMILY SAMPLES HAVE BEEN SUBMITTED FOR TESTING

The lab may perform confirmation of parental relationships for quality control or other purposes. See informed consent for more details. ☐ Check here to opt-out

LAST NAME* | FIRST NAME*

SEX ASSIGNED AT BIRTH* | DATE OF BIRTH (MM/DD/YYYY)*

RELATION TO PRIMARY PATIENT* | AFFECTED/UNAFFECTED STATUS*

SAMPLE COLLECTION DATE* (MM/DD/YYYY)

SAMPLE TYPE*: ◯ Blood ◯ Buccal/Saliva

◯ Extracted DNA & DNA Source (Blood, Buccal/Saliva, Tissue, Fibroblast): _____ ◯ Other: _____

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☐ Check this box if you are a New York state resident and give permission for Fulgent to retain any remaining sample longer than 60 days after sample collection.

☐ Opt out of research

X _____ Patient Signature (Required for billing purposes) | _____ Date (MM/DD/YYYY)

LAST NAME* | FIRST NAME*

SEX ASSIGNED AT BIRTH* | DATE OF BIRTH (MM/DD/YYYY)*

RELATION TO PRIMARY PATIENT* | AFFECTED/UNAFFECTED STATUS*

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☐ Check this box if you are a New York state resident and give permission for Fulgent to retain any remaining sample longer than 60 days after sample collection.

☐ Opt out of research

X _____ Patient Signature (Required for billing purposes) | _____ Date (MM/DD/YYYY)

BILLING OPTIONS

Please select a billing option and complete the relevant fields below: ◯ Insurance ◯ Institution ◯ Self-Pay

By signing above, the patient or payor authorizes Fulgent and its entities to contact them directly (including via text), and authorizes Fulgent and its entities to release medical information concerning the test to the assigned insurance company.

INSURANCE/BILLING INFORMATION

Please attach front and back of all insurance cards, ABN, medical criteria form

ICD-10 VALID CODE | REFERRAL/PRIOR AUTH | HOSPITAL STATUS WHEN SPECIMEN COLLECTED, MUST CHOOSE ONE*: ◯ Hospital Inpatient ◯ Hospital Outpatient ◯ Non-Hospital Outreach/Clinic Patient

PRIMARY INSURANCE ID | INSURANCE NAME | STATE | GROUP | INSURANCE PHONE #

INSURANCE PLAN | NAME OF INSURED | RELATION TO PATIENT | DATE OF BIRTH (MM/DD/YYYY)

SECONDARY INSURANCE ID | INSURANCE NAME | STATE | GROUP | INSURANCE PHONE #

INSURANCE ID | NAME OF INSURED | RELATION TO PATIENT | DATE OF BIRTH (MM/DD/YYYY)

INSTITUTIONAL BILLING

◯ Use institution information above for billing

◯ Use information below for billing

INSTITUTION/PRACTICE NAME | ATTENTION TO

ADDRESS

CITY | STATE | POSTAL CODE | COUNTRY

PHONE | EMAIL

SELF-PAY

By signing above, the patient or payor authorizes Fulgent and its entities to contact to contact them directly, and use the provided billing instructions to bill the indicated method.

◯ Use patient information above for billing

◯ Use information below for billing

PAYOR LAST NAME | PAYOR FIRST NAME

ADDRESS

CITY | STATE | POSTAL CODE | COUNTRY

PHONE | EMAIL

 | CLIA 05D2043189 | D# TRF-Whole Exome/Genome_RNA-Seq_2025-V3

Whole Exome/Genome & RNA-Sequencing (RISE)

CLINICAL INFORMATION

CLINICAL DETAILS

Check all that apply and provide details of any selected indications:

- ☐ Mosaicism
- ☐ Consanguinity
- ☐ Bone Marrow Transplant
- ☐ Organ Transplant
- ☐ Known Chromosomal Gain/Loss
- ☐ Known Gene Gain/Loss

There are many factors which may affect genetic diagnostic testing: such as gene-gene interactions, high-risk ethnicity groups, and transplants. Please list any that may apply.

CLINICAL PRESENTATION

Please indicate any clinical presentations and/or findings that may be relevant to genetic testing:

- Behavior
- Conditions
- Pedigree/Family History
- Phenotypes
- Physical
- Symptoms

There are many presentations which may not seem like a direct association for disease. Please list the most suspected presentations and attach detailed medical records and/or pedigree.

CLINICAL TESTING

Please indicate any clinical presentations and/or findings that may be relevant to genetic testing:

- Karyotype
- Previous Genetic Testing
- Vision
- Hearing
- Growth Measurements
- Biochemical Testing
- Imaging
- Pathology Reports

Please also include tests that had a negative result. These tests help our clinical staff process the results of your testing.

FAMILY HISTORY

FAMILY MEMBER 1

LAST NAME | FIRST NAME

RELATION TO PATIENT

SEX ASSIGNED AT BIRTH

○ Male ○ Female ○ Unknown

DIAGNOSIS AND/OR SYMPTOMS

AGE OF ONSET | DOB (MM/DD/YYYY)

FAMILY MEMBER 2

LAST NAME | FIRST NAME

RELATION TO PATIENT

SEX ASSIGNED AT BIRTH

○ Male ○ Female ○ Unknown

DIAGNOSIS AND/OR SYMPTOMS

AGE OF ONSET | DOB (MM/DD/YYYY)

 | CLIA 05D2043189 | D# TRF-Whole Exome/Genome_RNA-Seq_2025-V3

Whole Exome/Genome & RNA-Sequencing (RISE)

INSTRUCTIONS

1. Complete the patient and provider information section.
2. Read and sign the informed consent policy statement. The complete patient informed consent form for genetic testing can be found on FulgentGenetics.com. Signature from the provider on Page 1 of the TRF is required for all testing. Signature from the patient is required for billing purposes and communication consent.
3. Select or write in the test name and indicate any relevant test options. Please call us if you have any questions.
4. Visit our website for our most updated list of available genes.
5. For Duo/Trio testing, please complete the Family Samples section or submit a separate TRF for each sample.
6. Please visit FulgentGenetics.com for specimen requirements.
7. Extracted DNA must be extracted from a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by CAP and/or CMS.

REQUIRED FOR INSURANCE CHECKLIST

- ☐ Detailed medical record (pedigree if available)
- ☐ ICD-10 code(s)
- ☐ Physician, patient, and insured signatures
- ☐ Copy of insurance card(s) - front/back
- ☐ Insurer specific forms (i.e. ABN)
- ☐ Insurance authorization, if available
- ☐ For medicare, medicare criteria form is required

For the most updated information and limitations on our products and services, please visit FulgentGenetics.com.

4399 Santa Anita Ave., El Monte, CA 91731 | www.FulgentGenetics.com | info@fulgentgenetics.com | **P** +1 626.350.0537 | **F** +1 626.454.1667

 | CLIA 05D2043189 | D# TRF-Whole Exome/Genome_RNA-Seq_2025-V3