# bebegene® Newborn Genetic Screening Test Requisition Form

<International Distributor>

## ACCOUNT / ORDERING PHYSICIAN / PROVIDER

Physician / First Name _____ Last Name _____

Hospital / Clinic _____

Address _____

Email _____ Phone _____ Fax _____

## PATIENT INFORMATION

First Name _____

Last Name _____

DOB(DD/MM/YYYY) _____

Gender ☐ Male ☐ Female

Patient ID _____

## SPECIMEN INFORMATION

Date of draw(DD/MM/YYYY) _____

Specimen type ☐ Cord blood 1.0mL ☐ EDTA blood 1.0mL

Medical Record # _____

Family Histories

☐ Yes(Name of Condition): _____

☐ Not sure ☐ No

## TEST INFORMATION

☐ Bebegene Lite : deletions/duplications

☐ Bebegene Basic : deletions/duplications, AR and X-linked disorders screening, Wilson's, Hearing loss

☐ Bebegene Premium : deletions/duplications, AR and X-linked disorders screening, Wilson's, Hearing loss, and Dominant and X-linked disorder screening

## GENERAL INFORMATION & LIMITATIONS

bebegene® is a screening test for 117 rare genetic diseases related to developmental disorders of newborn babies. It checks only the copy number variations-microdeletion, duplication of relevant chromosomal region. Therefore, abnormalities caused by other chromosomal regions and other genetic mutations (point mutations, translocation, inversion, mosaicism, etc.) not included in this test are not detected. If pathogenic CNV's are detected, follow up testing may be recommended to confirm the result.

Wilson's disease is a hereditary disorder caused by abnormal copper metabolism. The symptoms include personality disorder, learning disability, and walking disorder. This test can detect 95% of Wilson's disease by analyzing markers and mutant genes that are known to cause Wilson's disease. Because it is screening test, not diagnostic test, if pathogenic variants are detected, follow up testing may be recommended to confirm the result.

The gene variants were elucidated from extracted genomic material analyzed on an Illumina Global Screening Array-based assay designed to detect clinically relevant single-nucleotide polymorphisms (SNPs). Detected variants were evaluated using genotype quality, minor allele frequency, and curated clinical database for pathogenicity

## TEST METHOD

Chromosomal Microarray (SNP Array)

## CONFIRMATION OF INFORMED CONSENT

### PATIENT CONSENT

I have read the information on the consent form and discussed it with my health care provider. I have been given the opportunity to ask questions and have them answered about the tests ordered. I authorize collection and analysis of the necessary sample(s).

Date (dd/mm/yy): _____

Patient Name: _____ (signature)

### PHYSICIAN CONSENT

I certify that the patient has been provided information and limitations of the test. I have verified that the contents of this referral are correct and confirm that this test is medically necessary for the patient.

Date (dd/mm/yy): _____

Physician Name: _____ (signature)

EDGC EONE-DIAGNOMICS Genome Center

#143, Gaetbeol-ro, Yeonsu-gu, Incheon, 21999, South Korea | Tel: +82-32-713-2100 | e-mail: cs.global@edgc.com