Nationwide Children's
When your child needs a hospital, everything matters.

Nationwide Children's Laboratory Services
Institute for Genomic Medicine (IGM) Clinical Laboratory
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Website: NationwideChildrens.org/Lab

Genome Sequencing (GS) Reanalysis Request Form

Patient (Proband) Name: _____

Patient (Proband) DOB: _____

Patient (Proband) MRN: _____

Or Place a Patient (Proband) ID Label Here

(Label Must Contain the Name and DOB)

PATIENT IDENTIFICATION

To Request Genome Sequencing (GS) Reanalysis:

Please note: GS Reanalysis request can only be processed for patients who previously had GS performed by the IGM Clinical Laboratory with a previous submission of a completed GS informed consent form.

1. If patient previously had rapid GS (rGS) performed at IGM, a GS consent is required due to the secondary finding consent option. New samples will not be required.
2. A GS consent is required if a new parental sample(s) is being submitted, or if the patient who previously had GS performed is now ≥18 and is able to provide consent.
3. Check the **Epic Media tab** for patient's previous ***Genome Sequencing (GS) Clinical Information Form.*** Email IGMLabGeneticCounselors@NationwideChildrens.org if you need assistance finding this document.
4. Please review the previous ***GS Clinical Information Form*** and complete the below sections. Add additional medical problems the patient developed, and/or remove clinical features listed on the ***GS Clinical Information Form*** which are no longer thought to be relevant.
5. Send this completed form with provider signature and date, along with any other clinical documents relevant to changes in the patient's clinical features, to the FAX# (614) 355-4454 or to the email IGMLabGeneticCounselors@NationwideChildrens.org.

Clinical Features Information

Any changes in the proband clinical features since the previous GS analysis?

❑ No ❑ Yes (list below)

Additional / Newly Developed Clinical Features:

1. _____
2. _____
3. _____
4. _____
5. _____
6.

Removal of Clinical Features Used in Previous GS Analysis:

1. _____
2. _____
3.

Tests Performed Since Previous GS Analysis

Please include/attach result information (e.g., lab results, imaging, biopsy, etc.)

Ordering Healthcare Provider or Qualified Healthcare Provider Signature:

I have reviewed the patient's clinical features listed on the ***Genome Sequencing (GS) Clinical Information Form***, which was used in the patient's previous GS analysis. Above, I have provided updated information on the patient's clinical features. I accept responsibility for receiving the GS Reanalysis test results and will ensure that genetic counseling is provided upon delivery of the test results.

Healthcare Provider Signature: _____ Date: _____ Time: _____

Printed Name: _____