

This requisition form can be used to submit a specimen for the Behind the Seizure® program, a complimentary Invitae epilepsy panel U.S. testing program. Please confirm that the patient meets the eligibility requirements for the program. To submit orders for genetic testing outside of this program, please order through Invitae's online portal or use a standard requisition form, accessible at [www.invitae.com/order-forms](http://www.invitae.com/order-forms).

## REQUIRED PROGRAM ELIGIBILITY

(Please check both boxes and enter patient age in months)

Patient is currently under 8 years of age **AND**  Patient has had an unprovoked seizure

**Required:** Age of child (in months) at onset of unprovoked seizures: \_\_\_\_\_ months

PATIENT INFORMATION		
First name	MI	Last name
Date of birth (MM/DD/YYYY)	Biological sex <input type="radio"/> M <input type="radio"/> F	MRN (medical record number)
Ancestry <input type="radio"/> Asian <input type="radio"/> Black/African American <input type="radio"/> White/Caucasian <input type="radio"/> Ashkenazi Jewish <input type="radio"/> Hispanic <input type="radio"/> Native American <input type="radio"/> Pacific Islander <input type="radio"/> French Canadian <input type="radio"/> Sephardic Jewish <input type="radio"/> Mediterranean <input type="radio"/> Other: _____		
Phone	Email address	
Address		City
State	Zip code	Country

SPECIMEN INFORMATION
Label each tube with the patient's full name, date of birth, and specimen collection date. A requisition form MUST accompany each specimen. <a href="http://www.invitae.com/specimen-requirements">www.invitae.com/specimen-requirements</a>
Specimen type : <input type="radio"/> Blood <input type="radio"/> Saliva <input type="radio"/> Assisted saliva <input type="radio"/> DNA - source: _____ <i>DNA must be extracted in a CLIA or other suitably certified laboratory</i> <i>We are unable to accept blood/saliva from patients with:</i> <ul style="list-style-type: none"> <li>• Allogeneic bone marrow transplants</li> <li>• Blood transfusion &lt;2 weeks prior to specimen collection</li> </ul>
▶ <b>Collection date (MM/DD/YYYY)</b> <i>If not provided, date will be 1 day prior to our receipt of specimen. For DNA, provide date retrieved from archive.</i>
Special cases : <input type="radio"/> History of/current hematologic malignancy

REASON FOR TESTING
<b>Previous results</b> (if applicable and not included in clinical criteria - enclose copy of report)

ORGANIZATION INFORMATION	
<b>Organization name and address</b>	
Organization name	
Phone	Fax
Address	
City	
State	Zip code
Country	
<b>Primary clinical contact</b>	
Name	Role/title
Phone	NPI
Email address (for report access)	
<b>Ordering physician</b>	
<input type="radio"/> Same as primary clinical contact	
Name	NPI
Email address (for report access)	
<b>Additional clinical or laboratory contact (optional)</b>	
Name	Email address (for report access)

**INVITAE PARTNER CODE**
**BEHIND THE SEIZURE**

FAMILY VARIANT TESTING				
Invitae's family variant testing programs involves full analysis of the gene in which the original family member's variant was identified. For more information, visit <a href="http://www.invitae.com/family-testing">www.invitae.com/family-testing</a> .				
Please attach the proband's clinical report or provide Invitae RQ#	INVITAE PROBAND RQ#	RELATIONSHIP TO PROBAND	GENE(S)	VARIANT(S)

Medical history:	Y	N	UNKNOWN	Development	Y	N	UNKNOWN
<b>Seizure types</b>							
Generalized onset motor seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Intellectual disability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Generalized onset nonmotor (absence) seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Motor developmental delay	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Focal seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Language developmental delay	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Febrile seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Limited or absent speech	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Infantile spasms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Autism spectrum disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Developmental delay preceded seizure onset	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Family history of epilepsy (please provide details below)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Developmental regression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Y = test performed and/or medical history taken AND material finding reported; N = test performed and/or medical history taken AND no material finding; Unknown = not in medical record and/or test not performed

**Medical history (continued):**

<b>Tone and movement</b>	<b>Y</b>	<b>N</b>	<b>UNKNOWN</b>
Hypotonia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hypertonia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ataxia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dyskinesia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dystonia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spasticity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tremor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other movement disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Other clinical features</b>			
Microcephaly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Macrocephaly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dysmorphic facial features	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blindness or visual impairment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abnormal eye movements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<b>Previous test results (please append any relevant results)</b>	<b>Y</b>	<b>N</b>	<b>UNKNOWN</b>
Abnormal EEG	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abnormal MRI	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Genetic (single gene, panel, exome, or CMA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Biochemical (including metabolic)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Previous CLN2 (TPP1) enzyme testing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<b>Seizure and treatment history</b>	<b>0</b>	<b>1-3</b>	<b>4-6</b>	<b>7-10</b>	<b>&gt;10</b>	<b>UNKNOWN</b>
Number of prolonged seizures (>5 min) in last 6 months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Number of convulsive seizures in last month	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Current number of anti-epilepsy drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Total number of anti-epilepsy drugs discontinued	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**ADDITIONAL CLINICAL INFORMATION**
**(Optional but useful for variant interpretation)**

Does this patient have a clinical or suspected diagnosis of a specific syndrome or disorder? If so, please provide diagnosis.

Clinical Diagnosis  Suspected Diagnosis

Please provide information about any relevant clinical findings not addressed in the checklist above.

If there is a family history of epilepsy, please specify who is affected and their symptoms/diagnosis.

**RE-REQUISITION**

Invitae offers one re-requisition at no additional charge within 90 days for genes related to the original clinical area. For more information and to request online, please visit [www.invitae.com/re-requisition](http://www.invitae.com/re-requisition).

**PRELIMINARY-EVIDENCE GENES**

Invitae's primary panels contain genes for which there is definitive evidence that variants in these genes cause specific diseases. Preliminary-evidence genes are genes for which there is only early evidence of a relationship between variants in these genes and specific diseases. All preliminary-evidence genes are indicated as such on the requisition form below.

**ASSAY**

Invitae is a CAP-accredited and CLIA-certified clinical diagnostic laboratory performing full-gene sequencing and deletion/ duplication analysis using next-generation sequencing technology (NGS). Search for details on the analysis of any gene in our test catalog at [www.invitae.com/physician/search](http://www.invitae.com/physician/search).

To request a complimentary specimen collection kit, visit [www.invitae.com/request-a-kit](http://www.invitae.com/request-a-kit).

**SHIPPING INSTRUCTIONS**

Please ship specimen to Invitae:

Attn: Invitae Client Services  
 1400 16th Street  
 San Francisco, CA 94103 USA

## TEST OPTIONS

Invitae continually updates its panels based on the most recent evidence. Please note that if an order is placed using an older version of this form, Invitae reserves the right to upgrade any ordered panel(s) to the current version(s).

TESTS INCLUDED IN THE PROGRAM			
Test code	Test name	# of gene(s)	Gene list
<input checked="" type="radio"/> 03401	Invitae Epilepsy Panel	151	ADSL, ALDH5A1, ALDH7A1, ALG13, ARG1, ARHGEF9, ARX, ATP1A2, ATP1A3, ATRX, BRAT1, C12orf57, CACNA1A, CACNA2D2, CARS2, CASK, CDKL5, CHD2, CHRNA2, CHRNA4, CHRN2, CLCN4, CLN2 (TPP1), CLN3, CLN5, CLN6, CLN8, CNTNAP2, CSTB, CTSD, DDC, DEPDC5, DNAJC5, DNMT1, DOCK7, DYRK1A, EEF1A2, EFHC1, EHMT1, EPM2A, FARS2, FOLR1, FOXG1, FRRS1L, GABBR2, GABRA1, GABRB2, GABRB3, GABRG2, GAMT, GATM, GLRA1, GNAO1, GOSR2, GRIN1, GRIN2A, GRIN2B, HCN1, HNRNPU, IER3IP1, IQSEC2, ITPA, JMJD1C, KANSL1, KCNA2, KCNB1, KCNC1, KCNH2, KCNJ10, KCNMA1, KCNQ2, KCNQ3, KCNT1, KCTD7, LGI1, LIAS, MBD5, MECP2, MEF2C, MFSDB, MOCS1, MOCS2, MTOR, NEDD4L, NEXMIF, NGLY1, NHLRC1, NPRL3, NRXN1, PACS1, PCDH19, PIGA, PIGN, PIGO, PLCB1, PNKD, PNKP, PNPO, POLG, PPT1, PRICKLE1, PRIMA1, PRRT2, PURA, QARS, RELN, ROGDI, SATB2, SCARB2, SCN1A, SCN1B, SCN2A, SCN3A, SCN8A, SCN9A, SERPINI1, SGCE, SIK1, SLC12A5, SLC13A5, SLC19A3, SLC25A12, SLC25A22, SLC2A1, SLC35A2, SLC6A1, SLC6A8, SLC9A6, SMC1A, SNX27, SPATA5, SPTAN1, ST3GAL5, STRADA, STX1B, STXBP1, SUOX, SYN1, SYNGAP1, SYNJ1, SZT2, TBC1D24, TCF4, TPK1, TSC1, TSC2, UBE3A, WDR45, WWOX, ZDHHC9, ZEB2
<input type="radio"/> 03401.1	Add-on preliminary-evidence genes <i>Fill in the circle to add these genes to your order</i>	35	ABAT, ARHGEF15, ATP6AP2, CACNA1H, CACNB4, CASR, CERS1, CNTN2, CPA6, DIAPH1, FASN, GABRD, GAL, GPHN, KCNA1, KCND2, KCNH5, KPNA7, LMNB2, NECAP1, PIGG, PIK3AP1, PRDM8, PRICKLE2, RBFOX1, RBFOX3, RYR3, SCNSA, SETD2, SLC35A3, SNAP25, SRPX2, ST3GAL3, TBL1XR1
<input type="radio"/> 03401.2	Add-on genes for glycine encephalopathy	3	AMT, GCSH, GLDC
<input type="radio"/> 03401.3	Add-on FLNA gene	1	FLNA
<input type="radio"/> 03401.4	Add-on PTEN gene	1	PTEN
<input type="radio"/> 03401.5	Add-on RANBP2 gene	1	RANBP2

By signing this form, the medical professional acknowledges that the individual/family member authorized to make decisions for the individual (collectively, the "Patient") has been supplied information regarding and consented to undergo genetic testing, substantially as set forth in Invitae's Informed Consent for Genetic Testing ([www.invitae.com/patient-consent](http://www.invitae.com/patient-consent)) and in connection with the Behind the Seizure program, and has been informed that Invitae may notify them of clinical updates related to genetic test results (in consultation with the ordering medical professional as indicated). The medical professional warrants that he/she will not seek reimbursement for this no-cost test from any third party, including but not limited to federal healthcare programs. The medical professional also hereby acknowledges that organization and clinician contact information provided in the order may be shared with third parties, that may contact the medical professional directly in connection with the Behind the Seizure program, and that they have made the Patient aware that third parties, may contact their medical professional regarding de-identified information gathered through the program. In addition to the above, I attest that I am the ordering physician, or I am authorized by the ordering physician to order this test, or I am authorized under applicable state law to order this test.

Medical professional signature (required)

Date (MM/DD/YYYY)