Behind the Seizure®
Program Eligibility/Clinical Criteria

FM145-10

This form is required to complete an online submission 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.

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 first name	Patient MI	Patient last name	Date of birth (MM/DD/YYYY)

BEHIND THE SEIZURE PROGRAM ELIGIBILITY/CLINICAL INFORMATION

Medical history:			
Seizure types	**Y**	**N**	**UNKNOWN**
Generalized onset motor seizures	◯	◯	◯
Generalized onset nonmotor (absence) seizures	◯	◯	◯
Focal seizures	◯	◯	◯
Febrile seizures	◯	◯	◯
Infantile spasms	◯	◯	◯
Other	◯	◯	◯
Family history of epilepsy (please provide details below)	◯	◯	◯
Development			
Intellectual disability	◯	◯	◯
Motor developmental delay	◯	◯	◯
Language developmental delay	◯	◯	◯
Limited or absent speech	◯	◯	◯
Autism spectrum disorder	◯	◯	◯
Developmental delay preceded seizure onset	◯	◯	◯
Developmental regression	◯	◯	◯
Tone and movement			
Hypotonia	◯	◯	◯
Hypertonia	◯	◯	◯
Ataxia	◯	◯	◯
Dyskinesia	◯	◯	◯
Dystonia	◯	◯	◯
Spasticity	◯	◯	◯
Tremor	◯	◯	◯
Other movement disorder	◯	◯	◯

Medical history (continued):			
Other clinical features	**Y**	**N**	**UNKNOWN**
Microcephaly	◯	◯	◯
Macrocephaly	◯	◯	◯
Dysmorphic facial features	◯	◯	◯
Blindness or visual impairment	◯	◯	◯
Abnormal eye movements	◯	◯	◯
Previous test results (please append any relevant results)			
Abnormal EEG	◯	◯	◯
Abnormal MRI	◯	◯	◯
Genetic (single gene, panel, exome, or CMA)	◯	◯	◯
Biochemical (including metabolic)	◯	◯	◯
Previous CLN2 (TPP1) enzyme testing	◯	◯	◯

Seizure and treatment history	**0**	**1-3**	**4-6**	**7-10**	**>10**	**UNKNOWN**
Number of prolonged seizures (>5 min) in last 6 months	◯	◯	◯	◯	◯	◯
Number of convulsive seizures in last month	◯	◯	◯	◯	◯	◯
Current number of anti-epilepsy drugs	◯	◯	◯	◯	◯	◯
Total number of anti-epilepsy drugs discontinued	◯	◯	◯	◯	◯	◯

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

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.

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) 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)