INVITAE

detect
Detect Muscular Dystrophy

Detect Muscular Dystrophy Program Eligibility Criteria

FM195-3

Patients in the U.S. and Canada suspected of having a muscular dystrophy are invited to take part in Detect Muscular Dystrophy, a sponsored testing program for muscular dystrophy.

The patient must meet the eligibility criteria below to qualify for the program. Please fill out, print, and sign this form and include it when sending in the specimen. Additional information about the ordering process can be found at www.invitae.com/DetectMD.

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.

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

PROGRAM ELIGIBILITY (MUST CHECK AT LEAST ONE)

This program is available to individuals in the U.S. and Canada suspected of having a muscular dystrophy (must check at least one):

- ◯ Progressive muscle weakness
- ◯ Elevated CK levels
- ◯ Presumptive positive DMD from Newborn Screening Program
- ◯ Cardiac or respiratory involvement
- ◯ Calf hypertrophy or pseudohypertrophy
- ◯ Muscle biopsy showing dystrophic changes and/or immunohistochemical evidence for specific muscular dystrophy subtype
- ◯ Clinical diagnosis of, or family history of, muscular dystrophy.* Specific clinical diagnosis, if known:

Please note that this program is not intended for carrier screening of unaffected individuals.

CLINICAL HISTORY – DETECT MUSCULAR DYSTROPHY PROGRAM

Optional clinical history (It is strongly encouraged to include notes, reports, and/or previous genetic test reults for this individual or affected family members. This information is useful for variant interpretation.)

MUSCULOSKELETAL	Y	N	UNKNOWN
Gait difficulties	◯	◯	◯
Ambulatory (if no, indicate age at which ambulation was lost below) Age at which ambulation was lost (if known): _____	◯	◯	◯
Scapular winging	◯	◯	◯
Calf hypertrophy	◯	◯	◯
Positive Gowers' maneuver	◯	◯	◯
Pain/cramps	◯	◯	◯
Joint contractures	◯	◯	◯
Asymmetry of weakness/wasting	◯	◯	◯
Foot drop	◯	◯	◯
Toe walking/achilles tendon tightness	◯	◯	◯
Inability to stand on toes	◯	◯	◯
Rippling muscle disease	◯	◯	◯
Diagnostic muscle biopsy (if yes, list specific findings below)	◯	◯	◯
Specific findings: _____			

RESPIRATORY	Y	N	UNKNOWN
Breathing difficulties	◯	◯	◯
Ventilator usage: day	◯	◯	◯
Ventilator usage: night	◯	◯	◯

CLINICAL HISTORY – DETECT MUSCULAR DYSTROPHY PROGRAM (continued)			
CARDIAC	**Y**	**N**	**UNKNOWN**
Dilated cardiomyopathy	○	○	○
Arrhythmia	○	○	○
OCULAR	**Y**	**N**	**UNKNOWN**
Cataracts	○	○	○
Severe myopia	○	○	○
Retinal degeneration	○	○	○
Ptosis or eye muscle weakness	○	○	○
CENTRAL NERVOUS SYSTEM	**Y**	**N**	**UNKNOWN**
Learning disabilities	○	○	○
Global developmental delays	○	○	○
Motor delays only	○	○	○
Nasal or dysarthric speech	○	○	○
Intellectual disability	○	○	○
SKIN FINDINGS	**Y**	**N**	**UNKNOWN**
Keratosis pilaris	○	○	○
Abnormal scar formation (keloid or atrophic)	○	○	○
Soft and velvety texture to the palmar skin of the hands and feet	○	○	○
MEDICAL	**Y**	**N**	**UNKNOWN**
Corticosteroid Use	○	○	○

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/forms). In connection with the Program the Patient 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) and has been informed that de-identified Patient data may be used and shared with third parties, for research and commercial purposes and, in the U.S., to contact their medical professional. For orders originating in Canada, the Patient has been informed that their personal information and specimen will be transferred to and processed in the U.S. and that de-identified Patient data may be used and shared for research and commercial purposes in the U.S. The medical professional warrants that he/she will not seek reimbursement for this no-charge 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, including commercial organizations, that may contact the medical professional directly in connection with the Program, and that they have made the Patient aware that de-identified Patient data may be used and shared with such third parties, for purposes which include contacting their medical professional directly in connection with the Program. A list of third party partners may be provided upon request. I attest that I am authorized under applicable state law to order this test.

Medical professional signature (required)	**Date (MM/DD/YYYY)**