Department of Obstetrics and Gynaecology

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Patient name: _____ (Last name) _____ (First name) Date of birth: ____ (DD) ____ (MM) ____ (YYYY)

Indication for ChromoSeq analysis

Please provide the following clinical information regarding the proband to be tested. If answering "yes," please provide details as much possible. Please also submit a clinical note if available. This information may help the interpretation of ChromoSeq result.

Features	No	Yes (Details)	Not known
Autism/Autistic spectrum	☐	☐	☐
Developmental delay	☐	☐	☐
Dysmorphic features	☐	☐	☐
Failure to thrive	☐	☐	☐
Hypotonia	☐	☐	☐
Microcephaly	☐	☐	☐
Macrocephaly	☐	☐	☐
Speech delay	☐	☐	☐
Seizure disorder	☐	☐	☐
Short stature	☐	☐	☐
Structural brain abnormalities	☐	☐	☐
Previous miscarriage(s)	☐	☐ consecutive miscarriages ☐ _____time(s) Result of previous genetic test(s) (if possible):	☐
Others (e.g., fetal ultrasound anomaly; Please specify):	☐		☐