Counsyl

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Report Date: 09/18/2017

MA E
DONOR 12220
DOB: [redacted]
Ethnicity: Mixed or Other Caucasian
Sample Type: EDTA Blood
Date of Collection:
Date Received: 09/08/2017
Date Tested: 09/18/2017
Barcode: 11004212187631
Indication: Egg or sperm donor

FEMA E
N/A

Foresight™ Carrier Screen

POSITIVE: CARRIER

ABOUT THIS TEST

The **Counsyl Foresight Carrier Screen** utilizes sequencing, maximizing coverage across all DNA regions tested, to help you learn about your chance to have a child with a genetic disease.

RESULTS SUMMARY

Risk Details	DONOR 12220	Partner
Panel Information	Foresight Carrier Screen Universal Panel Minus X-Linked **(102 conditions tested)**	N/A
POSITIVE: CARRIER 21-hydroxylase-deficient Congenital Adrenal Hyperplasia **Reproductive Risk: 1 in 230** **Inheritance: Autosomal Recessive**	**CARRIER*** NM_000500.7(CYP21A2):c.518T>A (I173N) heterozygote	The reproductive risk presented is based on a hypothetical pairing with a partner of the same ethnic group. Carrier testing should be considered. See "Next Steps".

*Carriers generally do not experience symptoms.

No disease-causing mutations were detected in any other gene tested. A complete list of all conditions tested can be found on page 6.

CLINICAL NOTES

- None

NEXT STEPS

- Carrier testing should be considered for the diseases specified above for the patient's partner, as both parents must be carriers before a child is at high risk of developing the disease.
- Genetic counseling is recommended and patients may wish to discuss any positive results with blood relatives, as there is an increased chance that they are also carriers.

Counsyl has renamed its products effective July 19, 2017. The Family Prep Screen is now the Foresight Carrier Screen. The new names now appear on all communications from Counsyl. If you have any questions, please contact Counsyl directly.

POSITIVE: CARRIER

21-hydroxylase-deficient Congenital Adrenal Hyperplasia

Reproductive risk: 1 in 230
Risk before testing: 1 in 13,000

Gene: CYP21A2 | **Inheritance Pattern:** Autosomal Recessive

Patient	DONOR 12220	No partner tested
Result	Carrier	N/A
Variant(s)	NM_000500.7(CYP21A2):c.518T>A(I173N) heterozygote	N/A
Methodology	Analysis of homologous regions	N/A
Interpretation	This individual is a carrier of 21-hydroxylase-deficient congenital adrenal hyperplasia. Carriers generally do not experience symptoms. NM_000500.7(CYP21A2):c.518T>A is a classic 21-hydroxylase-deficient congenital adrenal hyperplasia mutation.	N/A
Detection rate	96%	N/A
Variants tested	CYP21A2 deletion, CYP21A2 duplication, CYP21A2 triplication, G111Vfs*21, I173N, L308FfsX6, P31L, Q319*, Q319*+CYP21A2dup, R357W, V281L, [I237N;V238E;M240K], c.293-13C>G.	N/A

What is 21-Hydroxylase-Deficient Congenital Adrenal Hyperplasia?

Congenital adrenal hyperplasia (CAH) refers to a group of genetic disorders that affect the body's adrenal glands. The adrenal glands are located above each kidney and regulate essential functions in the body, including the production of several important hormones. CAH occurs when the adrenal glands are unable to produce these hormones properly, resulting in a hormone imbalance.

More than 90% of of CAH cases are caused by deficiency of the 21-hydroxylase enzyme. When this enzyme is missing or present at low levels, the adrenal glands are unable to produce two critical hormones, cortisol and aldosterone. The body responds to this deficiency by producing an excess of male sex hormones, called androgens. Collectively, the excess androgen production and hormone deficiencies can lead to a variety of medical problems, which vary in severity depending on the form of CAH.

There are two major forms of 21-hydroxylase-deficient CAH: classic CAH and non-classic CAH.

CLASSIC

The most severe form, referred to as classic CAH, can be divided into two different subtypes: the salt-wasting type and the simple virilizing type (non salt-wasting type). The classic salt-wasting type is associated with near to complete deficiency of the enzyme, 21-hydroxylase, resulting in the complete inability to produce the hormones, cortisol and aldosterone. In this type, the body cannot retain enough sodium (salt). When too much salt is lost in the urine, it may lead to dehydration, vomiting, diarrhea, failure to thrive, heart rhythm abnormalities (arrhythmias), and shock; if not properly treated, death may occur in some cases. In addition, female newborns often have external genitalia that do not clearly appear either male or female (ambiguous genitalia), whereas male newborns may present with enlarged genitalia. Signs of early puberty (virilization) occur in both males and females with CAH. These symptoms may include: rapid growth and development in early childhood, but shorter than average height in adulthood, abnormal menstruation cycles for females, excess facial hair for females, early facial hair growth for males, severe acne, and infertility in both men and women.

The simple virilizing type of CAH is associated with partial 21-hydroxylase deficiency. Unlike the salt-wasting type, these individuals typically do not experience severe and life-threatening sodium deficiency symptoms as newborns. However, the majority of female newborns with this type will have ambiguous genitalia, and both male and female children may show signs of early puberty.

NON CLASSIC

The non-classic type (late-onset type) is the the least severe form of CAH and is caused by mild deficiency of the 21-hydroxylase enzyme. Individuals with this type may start experiencing symptoms related to excess androgen production in childhood, adolescence, or adulthood. Both males and females may exhibit rapid growth in childhood, shorter than average stature in adulthood, virilization, and infertility. Additionally, girls may experience symptoms of masculinization and abnormal menstruation. However, some individuals with non-classic CAH may never know they are affected because the symptoms are so mild.

How common is 21-Hydroxylase-Deficient Congenital Adrenal Hyperplasia?

The incidence of CAH varies by type and is more prevalent in certain ethnicities. Classic CAH occurs in approximately 1 in 15,000 births worldwide, while non-classic CAH is much more common, occurring in approximately 1 in 1,000 births. In some populations, namely individuals of Ashkenazi Jewish, Hispanic, Italian, and Yugoslav descent, the prevalence of the non-classic CAH can reach as high as 3-4 percent.

How is 21-Hydroxylase-Deficient Congenital Adrenal Hyperplasia treated?

Currently, there is no cure for CAH. However, treatments are available to address some of the associated symptoms. Patients benefit from taking hormone replacement medications, which work to increase levels of deficient hormones and suppress the overproduction of male hormones. Most people with classic CAH will need to take hormone medications for the rest of their life. Those with the less severe forms of CAH are sometimes able to stop taking these medications in adulthood and are typically treated with lower doses. Some individuals with non-classic CAH do not require any treatment. A multidisciplinary team of physicians, including an endocrinologist, will need to monitor the medication dosage, medication side effects, growth, and sexual development of patients who continue to receive treatment.

Newborn females with ambiguous genitalia may need surgery to correct the function and appearance of the external genitalia. Surgery, if needed, is most often performed during infancy, but can be performed later in life.

Treatments provided during pregnancy may reduce the degree of virilization in female fetuses. However, because the long term safety of prenatal treatment is unknown, these therapies are considered experimental and are not recommended by professional guidelines.

What is the prognosis for a person with 21-Hydroxylase-Deficient Congenital Adrenal Hyperplasia?

With early diagnosis and proper medication management, most individuals with CAH will have a normal life expectancy. Early death can occur during periods of significant sodium loss (salt crises) if medication dosage is not adequately adjusted, especially during times of illness or trauma. Problems with growth and development, infertility, ambiguous genitalia, and virilization are monitored by physicians on an ongoing basis.

Methods and Limitations

DONOR 12220 [Foresight Carrier Screen]: sequencing with copy number analysis, spinal muscular atrophy, and analysis of homologous regions.

Sequencing with copy number analysis

High-throughput sequencing and read depth-based copy number analysis are used to analyze the listed exons, as well as selected intergenic and intronic regions, of the genes in the Conditions Tested section of the report. The region of interest (ROI) of the test comprises these regions, in addition to the 20 intronic bases flanking each exon. In a minority of cases where genomic features (e.g., long homopolymers) compromise calling fidelity, the affected intronic bases are not included in the ROI. The ROI is sequenced to high coverage and the sequences are compared to standards and references of normal variation. More than 99% of all bases in the ROI are sequenced at greater than the minimum read depth. Mutations may not be detected in areas of lower sequence coverage. Small insertions and deletions may not be as accurately determined as single nucleotide variants. Genes that have closely related pseudogenes may be addressed by a different method. *CFTR* and *DMD* testing includes analysis for both large (exon-level) deletions and duplications with an average sensitivity of 99%, while other genes are only analyzed for large deletions with a sensitivity of >75%. However, the sensitivity may be higher for selected founder deletions. If *GJB2* is tested, two large upstream deletions which overlap *GJB6* and affect the expression of *GJB2*, del(*GJB6*-D13S1830) and del(*GJB6*-D13S1854), are also analyzed. Mosaicism or somatic variants present at low levels may not be detected. If detected, these may not be reported.

Detection rates are determined by using literature to estimate the fraction of disease alleles, weighted by frequency, that the methodology is unable to detect. Detection rates only account for analytical sensitivity and certain variants that have been previously described in the literature may not be reported if there is insufficient evidence for pathogenicity. Detection rates do not account for the disease-specific rates of de novo mutations.

All variants that are a recognized cause of the disease will be reported. In addition, variants that have not previously been established as a recognized cause of disease may be identified. In these cases, only variants classified as "likely" pathogenic are reported. Likely pathogenic variants are described elsewhere in the report as "likely to have a negative impact on gene function". Likely pathogenic variants are evaluated and classified by assessing the nature of the variant and reviewing reports of allele frequencies in cases and controls, functional studies, variant annotation and effect prediction, and segregation studies. Exon level duplications are assumed to be in tandem and are classified according to their predicted effect on the reading frame. Benign variants, variants of uncertain significance, and variants not directly associated with the intended disease phenotype are not reported. Curation summaries of reported variants are available upon request.

Spinal muscular atrophy

Targeted copy number analysis is used to determine the copy number of exon 7 of the *SMN1* gene relative to other genes. Other mutations may interfere with this analysis. Some individuals with two copies of *SMN1* are carriers with two *SMN1* genes on one chromosome and a *SMN1* deletion on the other chromosome. This is more likely in individuals who have 2 copies of the *SMN1* gene and are positive for the g.27134T>G SNP, which affects the reported residual risk; Ashkenazi Jewish or Asian patients with this genotype have a high post-test likelihood of being carriers for SMA and are reported as carriers. The g.27134T>G SNP is only reported in individuals who have 2 copies of *SMN1*.

Analysis of homologous regions

A combination of high-throughput sequencing, read depth-based copy number analysis, and targeted genotyping is used to determine the number of functional gene copies and/or the presence of selected loss of function mutations in certain genes that have homology to other regions. The precise breakpoints of large deletions in these genes cannot be determined, but are estimated from copy number analysis. High numbers of pseudogene copies may interfere with this analysis.

If *CYP21A2* is tested, patients who have one or more additional copies of the *CYP21A2* gene and a loss of function mutation may not actually be a carrier of 21-hydroxylase-deficient congenital adrenal hyperplasia (CAH). Because the true incidence of non-classic CAH is unknown, the residual carrier and reproductive risk numbers on the report are only based on published incidences for classic CAH. However, the published prevalence of non-classic CAH is highest in individuals of Ashkenazi Jewish, Hispanic, Italian, and Yugoslav descent. Therefore, the residual and reproductive risks are likely an underestimate of overall chances for 21-hydroxylase-deficient CAH, especially in the aforementioned populations, as they do not account for non-classic CAH. If *HBA1*/*HBA2* are tested, some individuals with four alpha globin genes may be carriers, with three genes on one chromosome and a deletion on the other chromosome. This and similar, but rare, carrier states, where complementary changes exist in both the gene and a pseudogene, may not be detected by the assay.

Limitations

In an unknown number of cases, nearby genetic variants may interfere with mutation detection. Other possible sources of diagnostic error include sample mix-up, trace contamination, bone marrow transplantation, blood transfusions and technical errors. This test is designed to detect and report germline alterations. While somatic variants present at low levels may be detected, these may not be reported. If more than one variant is detected in a gene, additional studies may be necessary to determine if those variants lie on the same chromosome or different chromosomes. The test does not fully address all inherited forms of intellectual disability, birth defects and genetic disease. A family history of any of these conditions may warrant additional evaluation. Furthermore, not all mutations will be identified in the genes analyzed and additional testing may be beneficial for some patients. For example, individuals of African, Southeast Asian, and Mediterranean ancestry are at increased risk for being carriers for hemoglobinopathies, which can be identified by CBC and hemoglobin electrophoresis or HPLC (*ACOG Practice Bulletin No 78 Obstet Gynecol 2007;109 229-37*).

This test was developed and its performance characteristics determined by Counsyl, Inc. It has not been cleared or approved by the US Food and Drug Administration (FDA). The FDA does not require this test to go through premarket review. This test is used for clinical purposes. It should not be regarded as investigational or for research. This laboratory is certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as qualified to perform high-complexity clinical testing. These results are adjunctive to the ordering physician's evaluation. CLIA Number: **#05D1102604**.

LAB DIRECTORS

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Conditions Tested

21-hydroxylase-deficient Congenital Adrenal Hyperplasia - **Gene:** CYP21A2. Autosomal Recessive. Analysis of Homologous Regions. **Variants (13):** CYP21A2 deletion, CYP21A2 duplication, CYP21A2 triplication, G111Vfs*21, I173N, L308FfsX6, P31L, Q319*, Q319*+CYP21A2dup, R357W, V281L, [I237N;V238E;M240K], c.293-13C>G. **Detection Rate:** Mixed or Other Caucasian 96%.

ABCC8-related Hyperinsulinism - **Gene:** ABCC8. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000352:1-39. **Detection Rate:** Mixed or Other Caucasian >99%.

Alkaptonuria - **Gene:** HGD. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000187:1-14. **Detection Rate:** Mixed or Other Caucasian >99%.

Alpha Thalassemia - **Genes:** HBA1, HBA2. Autosomal Recessive. Analysis of Homologous Regions. **Variants (13):** -(alpha)20.5, --BRIT, --MEDI, --MEDII, --SEA, --THAI or --FIL, -alpha3.7, -alpha4.2, HBA1+HBA2 deletion, Hb Constant Spring, anti3.7, anti4.2, del HS-40. **Detection Rate:** Unknown due to rarity of disease.

Alpha-1 Antitrypsin Deficiency - **Gene:** SERPINA1. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000295:2-5. **Detection Rate:** Mixed or Other Caucasian >99%.

Alpha-mannosidosis - **Gene:** MAN2B1. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000528:1-23. **Detection Rate:** Mixed or Other Caucasian >99%.

Alpha-sarcoglycanopathy - **Gene:** SGCA. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000023:1-9. **Detection Rate:** Mixed or Other Caucasian >99%.

Andermann Syndrome - **Gene:** SLC12A6. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_133647:1-25. **Detection Rate:** Mixed or Other Caucasian >99%.

ARSACS - **Gene:** SACS. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_014363:2-10. **Detection Rate:** Mixed or Other Caucasian 99%.

Aspartylglycosaminuria - **Gene:** AGA. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000027:1-9. **Detection Rate:** Mixed or Other Caucasian >99%.

Ataxia with Vitamin E Deficiency - **Gene:** TTPA. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000370:1-5. **Detection Rate:** Mixed or Other Caucasian >99%.

Ataxia-telangiectasia - **Gene:** ATM. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000051:2-63. **Detection Rate:** Mixed or Other Caucasian 98%.

Bardet-Biedl Syndrome, BBS1-related - **Gene:** BBS1. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_024649:1-17. **Detection Rate:** Mixed or Other Caucasian >99%.

Bardet-Biedl Syndrome, BBS10-related - **Gene:** BBS10. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_024685:1-2. **Detection Rate:** Mixed or Other Caucasian >99%.

Beta-sarcoglycanopathy - **Gene:** SGCB. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000232:1-6. **Detection Rate:** Mixed or Other Caucasian >99%.

Biotinidase Deficiency - **Gene:** BTD. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000060:1-4. **Detection Rate:** Mixed or Other Caucasian >99%.

Bloom Syndrome - **Gene:** BLM. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000057:2-22. **Detection Rate:** Mixed or Other Caucasian >99%.

Canavan Disease - **Gene:** ASPA. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000049:1-6. **Detection Rate:** Mixed or Other Caucasian 98%.

Carnitine Palmitoyltransferase IA Deficiency - **Gene:** CPT1A. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_001876:2-19. **Detection Rate:** Mixed or Other Caucasian >99%.

Carnitine Palmitoyltransferase II Deficiency - **Gene:** CPT2. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000098:1-5. **Detection Rate:** Mixed or Other Caucasian >99%.

Cartilage-hair Hypoplasia - **Gene:** RMRP. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exon:** NR_003051:1. **Detection Rate:** Mixed or Other Caucasian >99%.

Citrullinemia Type 1 - **Gene:** ASS1. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000050:3-16. **Detection Rate:** Mixed or Other Caucasian >99%.

CLN3-related Neuronal Ceroid Lipofuscinosis - **Gene:** CLN3. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_001042432:2-16. **Detection Rate:** Mixed or Other Caucasian >99%.

CLN5-related Neuronal Ceroid Lipofuscinosis - **Gene:** CLN5. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_006493:1-4. **Detection Rate:** Mixed or Other Caucasian >99%.

CNGB3-related Achromatopsia - **Gene:** CNGB3. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_019098:1-18. **Detection Rate:** Mixed or Other Caucasian >99%.

Cohen Syndrome - **Gene:** VPS13B. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_017890:2-62. **Detection Rate:** Mixed or Other Caucasian 97%.

Congenital Disorder of Glycosylation Type Ia - **Gene:** PMM2. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000303:1-8. **Detection Rate:** Mixed or Other Caucasian >99%.

Congenital Disorder of Glycosylation Type Ib - **Gene:** MPI. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_002435:1-8. **Detection Rate:** Mixed or Other Caucasian >99%.

Congenital Finnish Nephrosis - **Gene:** NPHS1. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_004646:1-29. **Detection Rate:** Mixed or Other Caucasian >99%.

Costeff Optic Atrophy Syndrome - **Gene:** OPA3. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_025136:1-2. **Detection Rate:** Mixed or Other Caucasian >99%.

Cystic Fibrosis - **Gene:** CFTR. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000492:1-27. IVS8-5T allele analysis is only reported in the presence of the R117H mutation. **Detection Rate:** Mixed or Other Caucasian >99%.

Cystinosis - **Gene:** CTNS. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_004937:3-12. **Detection Rate:** Mixed or Other Caucasian >99%.

D-bifunctional Protein Deficiency - **Gene:** HSD17B4. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000414:1-24. **Detection Rate:** Mixed or Other Caucasian 98%.

Dihydropyrimidine Dehydrogenase Deficiency - **Gene:** DPYD. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000110:1-23. **Detection Rate:** Mixed or Other Caucasian 98%.

Factor XI Deficiency - **Gene:** F11. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000128:2-15. **Detection Rate:** Mixed or Other Caucasian >99%.

Familial Dysautonomia - **Gene:** IKBKAP. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_003640:2-37. **Detection Rate:** Mixed or Other Caucasian >99%.

Familial Mediterranean Fever - **Gene:** MEFV. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000243:1-10. **Detection Rate:** Mixed or Other Caucasian >99%.

Fanconi Anemia Type C - **Gene:** FANCC. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000136:2-15. **Detection Rate:** Mixed or Other Caucasian >99%.

FKTN-related Disorders - **Gene:** FKTN. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_001079802:3-11. **Detection Rate:** Mixed or Other Caucasian >99%.

Galactosemia - **Gene:** GALT. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000155:1-11. **Detection Rate:** Mixed or Other Caucasian >99%.

Gaucher Disease - **Gene:** GBA. Autosomal Recessive. Analysis of Homologous Regions. **Variants (10):** D409V, D448H, IVS2+1G>A, L444P, N370S, R463C, R463H, R496H, V394L, p.L29Afs*18. **Detection Rate:** Mixed or Other Caucasian 60%.

GJB2-related DFNB1 Nonsyndromic Hearing Loss and Deafness - **Gene:** GJB2. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_004004:1-2. **Detection Rate:** Mixed or Other Caucasian >99%.

Glutaric Acidemia Type 1 - **Gene:** GCDH. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000159:2-12. **Detection Rate:** Mixed or Other Caucasian >99%.

Glycogen Storage Disease Type Ia - **Gene:** G6PC. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000151:1-5. **Detection Rate:** Mixed or Other Caucasian >99%.
Glycogen Storage Disease Type Ib - **Gene:** SLC37A4. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_001164277:3-11. **Detection Rate:** Mixed or Other Caucasian >99%.
Glycogen Storage Disease Type III - **Gene:** AGL. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000642:2-34. **Detection Rate:** Mixed or Other Caucasian >99%.
Glycogen Storage Disease Type V - **Gene:** PYGM. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_005609:1-20. **Detection Rate:** Mixed or Other Caucasian >99%.
GRACILE Syndrome - **Gene:** BCS1L. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_004328:3-9. **Detection Rate:** Mixed or Other Caucasian >99%.
HADHA-related Disorders - **Gene:** HADHA. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000182:1-20. **Detection Rate:** Mixed or Other Caucasian >99%.
Hb Beta Chain-related Hemoglobinopathy (Including Beta Thalassemia and Sickle Cell Disease) - **Gene:** HBB. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000518:1-3. **Detection Rate:** Mixed or Other Caucasian >99%.
Hereditary Fructose Intolerance - **Gene:** ALDOB. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000035:2-9. **Detection Rate:** Mixed or Other Caucasian >99%.
Herlitz Junctional Epidermolysis Bullosa, LAMA3-related - **Gene:** LAMA3. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000227:1-38. **Detection Rate:** Mixed or Other Caucasian >99%.
Herlitz Junctional Epidermolysis Bullosa, LAMB3-related - **Gene:** LAMB3. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000228:2-23. **Detection Rate:** Mixed or Other Caucasian >99%.
Herlitz Junctional Epidermolysis Bullosa, LAMC2-related - **Gene:** LAMC2. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_005562:1-23. **Detection Rate:** Mixed or Other Caucasian >99%.
Hexosaminidase A Deficiency (Including Tay-Sachs Disease) - **Gene:** HEXA. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000520:1-14. **Detection Rate:** Mixed or Other Caucasian >99%.
Homocystinuria Caused by Cystathionine Beta-synthase Deficiency - **Gene:** CBS. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000071:3-17. **Detection Rate:** Mixed or Other Caucasian >99%.
Hypophosphatasia, Autosomal Recessive - **Gene:** ALPL. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000478:2-12. **Detection Rate:** Mixed or Other Caucasian >99%.
Inclusion Body Myopathy 2 - **Gene:** GNE. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_001128227:1-12. **Detection Rate:** Mixed or Other Caucasian >99%.
Isovaleric Acidemia - **Gene:** IVD. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_002225:1-12. **Detection Rate:** Mixed or Other Caucasian >99%.
Joubert Syndrome 2 - **Gene:** TMEM216. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_001173990:1-5. **Detection Rate:** Mixed or Other Caucasian >99%.
Krabbe Disease - **Gene:** GALC. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000153:1-17. **Detection Rate:** Mixed or Other Caucasian >99%.
Lipoamide Dehydrogenase Deficiency - **Gene:** DLD. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000108:1-14. **Detection Rate:** Mixed or Other Caucasian >99%.
Maple Syrup Urine Disease Type 1B - **Gene:** BCKDHB. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_183050:1-10. **Detection Rate:** Mixed or Other Caucasian >99%.
Medium Chain Acyl-CoA Dehydrogenase Deficiency - **Gene:** ACADM. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000016:1-12. **Detection Rate:** Mixed or Other Caucasian >99%.
Megalencephalic Leukoencephalopathy with Subcortical Cysts - **Gene:** MLC1. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_015166:2-12. **Detection Rate:** Mixed or Other Caucasian >99%.
Metachromatic Leukodystrophy - **Gene:** ARSA. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000487:1-8. **Detection Rate:** Mixed or Other Caucasian >99%.
Mucolipidosis IV - **Gene:** MCOLN1. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_020533:1-14. **Detection Rate:** Mixed or Other Caucasian >99%.
Mucopolysaccharidosis Type I - **Gene:** IDUA. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000203:1-14. **Detection Rate:** Mixed or Other Caucasian >99%.
Muscle-eye-brain Disease - **Gene:** POMGNT1. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_017739:2-22. **Detection Rate:** Mixed or Other Caucasian 96%.
NEB-related Nemaline Myopathy - **Gene:** NEB. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_001271208:3-80,117-183. **Detection Rate:** Mixed or Other Caucasian 92%.
Niemann-Pick Disease Type C - **Gene:** NPC1. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000271:1-25. **Detection Rate:** Mixed or Other Caucasian >99%.
Niemann-Pick Disease, SMPD1-associated - **Gene:** SMPD1. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000543:1-6. **Detection Rate:** Mixed or Other Caucasian >99%.
Nijmegen Breakage Syndrome - **Gene:** NBN. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_002485:1-16. **Detection Rate:** Mixed or Other Caucasian >99%.
Northern Epilepsy - **Gene:** CLN8. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_018941:2-3. **Detection Rate:** Mixed or Other Caucasian >99%.
PCDH15-related Disorders - **Gene:** PCDH15. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_033056:2-33. **Detection Rate:** Mixed or Other Caucasian 93%.
Pendred Syndrome - **Gene:** SLC26A4. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000441:2-21. **Detection Rate:** Mixed or Other Caucasian >99%.
PEX1-related Zellweger Syndrome Spectrum - **Gene:** PEX1. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000466:1-24. **Detection Rate:** Mixed or Other Caucasian >99%.
Phenylalanine Hydroxylase Deficiency - **Gene:** PAH. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000277:1-13. **Detection Rate:** Mixed or Other Caucasian >99%.
PKHD1-related Autosomal Recessive Polycystic Kidney Disease - **Gene:** PKHD1. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_138694:2-67. **Detection Rate:** Mixed or Other Caucasian >99%.
Polyglandular Autoimmune Syndrome Type 1 - **Gene:** AIRE. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000383:1-14. **Detection Rate:** Mixed or Other Caucasian >99%.
Pompe Disease - **Gene:** GAA. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000152:2-20. **Detection Rate:** Mixed or Other Caucasian 98%.
PPT1-related Neuronal Ceroid Lipofuscinosis - **Gene:** PPT1. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000310:1-9. **Detection Rate:** Mixed or Other Caucasian >99%.
Primary Carnitine Deficiency - **Gene:** SLC22A5. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_003060:1-10. **Detection Rate:** Mixed or Other Caucasian >99%.
Primary Hyperoxaluria Type 1 - **Gene:** AGXT. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000030:1-11. **Detection Rate:** Mixed or Other Caucasian >99%.
Primary Hyperoxaluria Type 2 - **Gene:** GRHPR. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_012203:1-9. **Detection Rate:** Mixed or Other Caucasian >99%.
PROP1-related Combined Pituitary Hormone Deficiency - **Gene:** PROP1. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_006261:1-3. **Detection Rate:** Mixed or Other Caucasian >99%.
Pseudocholinesterase Deficiency - **Gene:** BCHE. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000055:2-4. **Detection Rate:** Mixed or Other Caucasian >99%.
Pycnodysostosis - **Gene:** CTSK. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000396:2-8. **Detection Rate:** Mixed or Other Caucasian >99%.
Rhizomelic Chondrodysplasia Punctata Type 1 - **Gene:** PEX7. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000288:1-10. **Detection Rate:** Mixed or Other Caucasian >99%.

Salla Disease - **Gene:** SLC17A5. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_012434:1-11. **Detection Rate:** Mixed or Other Caucasian 98%.
Segawa Syndrome - **Gene:** TH. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000360:1-13. **Detection Rate:** Mixed or Other Caucasian >99%.
Short Chain Acyl-CoA Dehydrogenase Deficiency - **Gene:** ACADS. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000017:1-10. **Detection Rate:** Mixed or Other Caucasian >99%.
Sjogren-Larsson Syndrome - **Gene:** ALDH3A2. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000382:1-10. **Detection Rate:** Mixed or Other Caucasian 97%.
Smith-Lemli-Opitz Syndrome - **Gene:** DHCR7. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_001360:3-9. **Detection Rate:** Mixed or Other Caucasian >99%.
Spinal Muscular Atrophy - **Gene:** SMN1. Autosomal Recessive. Spinal Muscular Atrophy. **Variant (1):** SMN1 copy number. **Detection Rate:** Mixed or Other Caucasian 95%.
Steroid-resistant Nephrotic Syndrome - **Gene:** NPHS2. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_014625:1-8. **Detection Rate:** Mixed or Other Caucasian >99%.
Sulfate Transporter-related Osteochondrodysplasia - **Gene:** SLC26A2. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000112:2-3. **Detection Rate:** Mixed or Other Caucasian >99%.
TPP1-related Neuronal Ceroid Lipofuscinosis - **Gene:** TPP1. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000391:1-13. **Detection Rate:** Mixed or Other Caucasian >99%.
Tyrosinemia Type I - **Gene:** FAH. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000137:1-14. **Detection Rate:** Mixed or Other Caucasian >99%.
Usher Syndrome Type 3 - **Gene:** CLRN1. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_174878:1-3. **Detection Rate:** Mixed or Other Caucasian >99%.
Very Long Chain Acyl-CoA Dehydrogenase Deficiency - **Gene:** ACADVL. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000018:1-20. **Detection Rate:** Mixed or Other Caucasian >99%.
Wilson Disease - **Gene:** ATP7B. Autosomal Recessive. Sequencing with Copy Number Analysis. **Exons:** NM_000053:1-21. **Detection Rate:** Mixed or Other Caucasian >99%.

Risk Calculations

Below are the risk calculations for all conditions tested. Since negative results do not completely rule out the possibility of being a carrier, the **residual risk** represents the patient's post-test likelihood of being a carrier and the **reproductive risk** represents the likelihood the patient's future children could inherit each disease. These risks are inherent to all carrier screening tests, may vary by ethnicity, are predicated on a negative family history and are present even after a negative test result. Inaccurate reporting of ethnicity may cause errors in risk calculation. The reproductive risk presented is based on a hypothetical pairing with a partner of the same ethnic group.

†Indicates a positive result. See the full clinical report for interpretation and details.

Disease	DONOR 12220 Residual Risk	Reproductive Risk
21-hydroxylase-deficient Congenital Adrenal Hyperplasia	NM_000500.7(CYP21A2):c.518T>A(I173N) heterozygote †	1 in 230
ABCC8-related Hyperinsulinism	1 in 11,000	< 1 in 1,000,000
Alkaptonuria	1 in 6,800	< 1 in 1,000,000
Alpha Thalassemia	Alpha globin status: aa/aa.	Not calculated
Alpha-1 Antitrypsin Deficiency	1 in 2,700	1 in 300,000
Alpha-mannosidosis	1 in 35,000	< 1 in 1,000,000
Alpha-sarcoglycanopathy	1 in 45,000	< 1 in 1,000,000
Andermann Syndrome	< 1 in 50,000	< 1 in 1,000,000
ARSACS	< 1 in 44,000	< 1 in 1,000,000
Aspartylglycosaminuria	< 1 in 50,000	< 1 in 1,000,000
Ataxia with Vitamin E Deficiency	< 1 in 50,000	< 1 in 1,000,000
Ataxia-telangiectasia	1 in 8,200	< 1 in 1,000,000
Bardet-Biedl Syndrome, BBS1-related	1 in 16,000	< 1 in 1,000,000
Bardet-Biedl Syndrome, BBS10-related	1 in 16,000	< 1 in 1,000,000
Beta-sarcoglycanopathy	< 1 in 50,000	< 1 in 1,000,000
Biotinidase Deficiency	1 in 13,000	1 in 670,000
Bloom Syndrome	< 1 in 50,000	< 1 in 1,000,000
Canavan Disease	< 1 in 31,000	< 1 in 1,000,000
Carnitine Palmitoyltransferase IA Deficiency	< 1 in 50,000	< 1 in 1,000,000
Carnitine Palmitoyltransferase II Deficiency	< 1 in 50,000	< 1 in 1,000,000
Cartilage-hair Hypoplasia	< 1 in 50,000	< 1 in 1,000,000
Citrullinemia Type 1	1 in 12,000	< 1 in 1,000,000
CLN3-related Neuronal Ceroid Lipofuscinosis	1 in 22,000	< 1 in 1,000,000
CLN5-related Neuronal Ceroid Lipofuscinosis	< 1 in 50,000	< 1 in 1,000,000
CNGB3-related Achromatopsia	1 in 11,000	< 1 in 1,000,000
Cohen Syndrome	< 1 in 15,000	< 1 in 1,000,000
Congenital Disorder of Glycosylation Type Ia	1 in 16,000	< 1 in 1,000,000
Congenital Disorder of Glycosylation Type Ib	< 1 in 50,000	< 1 in 1,000,000
Congenital Finnish Nephrosis	< 1 in 50,000	< 1 in 1,000,000
Costeff Optic Atrophy Syndrome	< 1 in 50,000	< 1 in 1,000,000
Cystic Fibrosis	1 in 2,700	1 in 290,000
Cystinosis	1 in 22,000	< 1 in 1,000,000
D-bifunctional Protein Deficiency	1 in 9,000	< 1 in 1,000,000
Dihydropyrimidine Dehydrogenase Deficiency	< 1 in 29,000	< 1 in 1,000,000
Factor XI Deficiency	< 1 in 50,000	< 1 in 1,000,000
Familial Dysautonomia	< 1 in 50,000	< 1 in 1,000,000
Familial Mediterranean Fever	< 1 in 50,000	< 1 in 1,000,000
Fanconi Anemia Type C	1 in 16,000	< 1 in 1,000,000
FKTN-related Disorders	< 1 in 50,000	< 1 in 1,000,000
Galactosemia	1 in 8,600	< 1 in 1,000,000
Gaucher Disease	1 in 280	1 in 120,000
GJB2-related DFNB1 Nonsyndromic Hearing Loss and Deafness	1 in 3,200	1 in 420,000
Glutaric Acidemia Type 1	1 in 10,000	< 1 in 1,000,000
Glycogen Storage Disease Type Ia	1 in 18,000	< 1 in 1,000,000
Glycogen Storage Disease Type Ib	1 in 35,000	< 1 in 1,000,000
Glycogen Storage Disease Type III	1 in 16,000	< 1 in 1,000,000
Glycogen Storage Disease Type V	1 in 16,000	< 1 in 1,000,000

Disease	DONOR 12220 Residual Risk	Reproductive Risk
GRACILE Syndrome	< 1 in 50,000	< 1 in 1,000,000
HADHA-related Disorders	1 in 15,000	< 1 in 1,000,000
Hb Beta Chain-related Hemoglobinopathy (Including Beta Thalassemia and Sickle Cell Disease)	1 in 5,000	1 in 990,000
Hereditary Fructose Intolerance	1 in 8,000	< 1 in 1,000,000
Herlitz Junctional Epidermolysis Bullosa, LAMA3-related	< 1 in 50,000	< 1 in 1,000,000
Herlitz Junctional Epidermolysis Bullosa, LAMB3-related	< 1 in 50,000	< 1 in 1,000,000
Herlitz Junctional Epidermolysis Bullosa, LAMC2-related	< 1 in 50,000	< 1 in 1,000,000
Hexosaminidase A Deficiency (Including Tay-Sachs Disease)	1 in 30,000	< 1 in 1,000,000
Homocystinuria Caused by Cystathionine Beta-synthase Deficiency	1 in 25,000	< 1 in 1,000,000
Hypophosphatasia, Autosomal Recessive	1 in 16,000	< 1 in 1,000,000
Inclusion Body Myopathy 2	< 1 in 50,000	< 1 in 1,000,000
Isovaleric Acidemia	1 in 25,000	< 1 in 1,000,000
Joubert Syndrome 2	< 1 in 50,000	< 1 in 1,000,000
Krabbe Disease	1 in 15,000	< 1 in 1,000,000
Lipoamide Dehydrogenase Deficiency	< 1 in 50,000	< 1 in 1,000,000
Maple Syrup Urine Disease Type 1B	1 in 25,000	< 1 in 1,000,000
Medium Chain Acyl-CoA Dehydrogenase Deficiency	1 in 5,900	< 1 in 1,000,000
Megalencephalic Leukoencephalopathy with Subcortical Cysts	< 1 in 50,000	< 1 in 1,000,000
Metachromatic Leukodystrophy	1 in 20,000	< 1 in 1,000,000
Mucolipidosis IV	< 1 in 50,000	< 1 in 1,000,000
Mucopolysaccharidosis Type I	1 in 16,000	< 1 in 1,000,000
Muscle-eye-brain Disease	< 1 in 12,000	< 1 in 1,000,000
NEB-related Nemaline Myopathy	< 1 in 6,700	< 1 in 1,000,000
Niemann-Pick Disease Type C	1 in 19,000	< 1 in 1,000,000
Niemann-Pick Disease, SMPD1-associated	1 in 25,000	< 1 in 1,000,000
Nijmegen Breakage Syndrome	1 in 16,000	< 1 in 1,000,000
Northern Epilepsy	< 1 in 50,000	< 1 in 1,000,000
PCDH15-related Disorders	1 in 5,300	< 1 in 1,000,000
Pendred Syndrome	1 in 7,000	< 1 in 1,000,000
PEX1-related Zellweger Syndrome Spectrum	1 in 11,000	< 1 in 1,000,000
Phenylalanine Hydroxylase Deficiency	1 in 5,000	1 in 990,000
PKHD1-related Autosomal Recessive Polycystic Kidney Disease	1 in 6,100	< 1 in 1,000,000
Polyglandular Autoimmune Syndrome Type 1	1 in 14,000	< 1 in 1,000,000
Pompe Disease	1 in 6,300	< 1 in 1,000,000
PPT1-related Neuronal Ceroid Lipofuscinosis	< 1 in 50,000	< 1 in 1,000,000
Primary Carnitine Deficiency	< 1 in 50,000	< 1 in 1,000,000
Primary Hyperoxaluria Type 1	1 in 35,000	< 1 in 1,000,000
Primary Hyperoxaluria Type 2	< 1 in 50,000	< 1 in 1,000,000
PROP1-related Combined Pituitary Hormone Deficiency	1 in 11,000	< 1 in 1,000,000
Pseudocholinesterase Deficiency (Mild Condition)	1 in 2,700	1 in 300,000
Pycnodysostosis	< 1 in 50,000	< 1 in 1,000,000
Rhizomelic Chondrodysplasia Punctata Type 1	1 in 16,000	< 1 in 1,000,000
Salla Disease	< 1 in 30,000	< 1 in 1,000,000
Segawa Syndrome	< 1 in 50,000	< 1 in 1,000,000
Short Chain Acyl-CoA Dehydrogenase Deficiency	1 in 16,000	< 1 in 1,000,000
Sjogren-Larsson Syndrome	1 in 9,100	< 1 in 1,000,000
Smith-Lemli-Opitz Syndrome	1 in 4,900	1 in 970,000
Spinal Muscular Atrophy	Negative for g.27134T>G SNP SMN1: 2 copies 1 in 770	1 in 110,000
Steroid-resistant Nephrotic Syndrome	1 in 40,000	< 1 in 1,000,000
Sulfate Transporter-related Osteochondrodysplasia	1 in 11,000	< 1 in 1,000,000
TPP1-related Neuronal Ceroid Lipofuscinosis	1 in 30,000	< 1 in 1,000,000
Tyrosinemia Type I	1 in 17,000	< 1 in 1,000,000
Usher Syndrome Type 3	< 1 in 50,000	< 1 in 1,000,000
Very Long Chain Acyl-CoA Dehydrogenase Deficiency	1 in 8,800	< 1 in 1,000,000
Wilson Disease	1 in 8,600	< 1 in 1,000,000

PREVENTION GENETICS

NAME	PATIENT ID
DONOR 12220,	[redacted]

PATIENT INFORMATION	SPECIMEN INFORMATION	PROVIDER INFORMATION
DONOR 12220, ID#: None Listed DOB: [redacted] Sex: Male	Type: DNA From Previous Test Collected: May 10, 2021 Received: June 10, 2021 PG ID: [redacted]	Jeffrey Olliffe, MD Katherine Hornberger, MS, CGC Seattle Sperm Bank

MOLECULAR GENETICS REPORT:
Targeted Testing via *CEP135* Gene Sequencing

SUMMARY OF RESULTS **Targeted Variant Detected**

Gene, Transcript	Mode of Inheritance, Gene OMIM	DNA Variations, Predicted Effects, Zygosity	ClinVar ID	Highest Allele Frequency in a gnomAD Population	In Silico Missense Predictions	Interpretation
CEP135, NM_025009.4	AR, 611423	c.1875T>G, p.Tyr625*, Heterozygous	Not listed in ClinVar	Not Present	Not Applicable	LIKELY PATHOGENIC

Mode of Inheritance: Autosomal Dominant=AD, Autosomal Recessive=AR, X-Linked=XL
ClinVar ID: Variant accession (www.ncbi.nlm.nih.gov/clinvar)
GnomAD: Allele Frequency registered in a large population database (gnomad.broadinstitute.org). Value listed is the highest allele frequency reported within one of seven population categories recognized in gnomAD v.2.0 (The "Other" population is excluded).
Missense Predictions: Summarized output (Damaging, Conflicting, or Tolerated) via PolyPhen-2, SIFT, MutationTaster, and FATHMM (PMID: 26555599).

RESULTS AND INTERPRETATIONS: This patient is heterozygous in the *CEP135* gene for a familial variant designated c.1875T>G, which is predicted to result in a premature protein termination (p.Tyr625*). To our knowledge, this variant has not been reported but is expected to be pathogenic. Other truncating variants in the *CEP135* have been reported in patients with primary microcephaly (HGMD database, Hussain et al. 2012. PubMed ID: 22521416; Shaheen et al. 2019. PubMed ID: 30214071).

Pathogenic variants in *CEP135* have been associated with autosomal recessive primary microcephaly 8 (OMIM #614673).

These results should be interpreted in context of clinical findings, family history and other laboratory data. All genetic tests have limitations. See limitations and other information for this test on the following page(s).

NOTES: Genetic counseling is recommended.

GENE(S) ANALYZED: *CEP135* (NM_025009.4) (only relevant region)

Electronically signed on July 02, 2021 by:
Ben Dorshorst, PhD
Human Molecular Geneticist

Electronically signed and reported on July 08, 2021 by:
Luke Drury, PhD, HCLD(ABB)
Human Molecular Geneticist

SUPPLEMENTAL INFORMATION V.18.09
SANGER SEQUENCING

Limitations of Test and Other Test Notes: Interpretation of the test results is limited by the information that is currently available. Better interpretation should be possible in the future as more data and knowledge about human genetics and this specific disorder are accumulated.

In exons where our sequencing did not reveal any variation between the two alleles, we cannot be certain that we were able to PCR amplify both of the patient's alleles. Occasionally, a patient may carry an allele which does not amplify, due for example to a deletion or a large insertion. In these cases, the report contains no information about the second allele. Similarly, our Sanger sequencing tests have almost no power to detect duplications, triplications, etc. of the gene sequences.

Only the indicated exons and roughly 10 bp of flanking non-coding sequence on each side were analyzed. Test reports contain no information about other portions of the gene, including many regulatory regions.

In nearly all cases, we are unable to determine the phase of sequence variants. In particular, when we find two likely causative variants for recessive disorders, we cannot be certain that the variants are on different alleles.

The ability to detect low-level mosaicism of variants is limited.

Runs of mononucleotide repeats (eg $(A)_n$ or $(T)_n$) with n >8 in the reference sequence are generally not analyzed because of strand slippage during PCR and cycle sequencing.

Unless otherwise indicated, the sequence data that we report are based on DNA isolated from a specific tissue (usually leukocytes). Test reports contain no information about gene sequences in other tissues.

We cannot be certain that the reference sequence(s) are correct. Exons, for example, may be misidentified. In cases where the genomic and mRNA sequences disagree, we use the genomic sequence as our reference.

We have confidence in our ability to track a specimen once it has been received by PreventionGenetics. However, we take no responsibility for specimen labeling errors that occur before the sample arrives at PreventionGenetics.

Genetic counseling to help to explain test results to the patients and to discuss reproductive or medical options is recommended.

Methodology: As required, DNA was extracted from the patient specimen. PCR was used to amplify the indicated exons plus additional flanking non-coding sequence. After cleaning of the PCR products, cycle sequencing was carried out using the ABI Big Dye Terminator v.3.1 kit. Products were resolved by electrophoresis on an ABI 3730xl capillary sequencer. In most cases, sequencing was performed in both forward and reverse directions.

Human Genome Variation Society (HGVS) recommendations are used to describe sequence variants (http://www.hgvs.org). All differences from the reference sequences are assigned to one of five interpretation categories (Pathogenic, Likely Pathogenic, Variant of Uncertain Significance, Likely Benign and Benign) per ACMG Guidelines (Richards et al. 2015. PubMed ID: 25741868). Rare variants and undocumented variants are nearly always classified as likely benign if there is no indication that they alter protein sequence or disrupt splicing. Benign variants are not listed in the reports, but are available upon request.

Data Transfer: PreventionGenetics recommends that DNA sequence information from this test be stored in the patient's electronic medical record. This will facilitate reinterpretation of the sequence in future, and will best benefit the patient and family members. Upon request, we will be pleased to transfer the sequence data.

FDA Notes: These results should be used in the context of available clinical findings, and should not be used as the sole basis for treatment. This test was developed and its performance characteristics determined by PreventionGenetics. US Food and Drug Administration (FDA) does not require this test to go through premarket FDA review. This test is used for clinical purposes. It should not be regarded as investigational or for research. This laboratory is certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as qualified to perform high complexity clinical laboratory testing.

Patient Information
Name: Donor 12220
Date of Birth: [redacted]
Sema4 ID: 20102399CS
Client ID: SEATSB-S412220
Indication: Carrier Testing

Specimen Information
Specimen Type: Blood
Date Collected: 05/18/2020
Date Received: 05/19/2020
Final Report: 06/01/2020

Referring Provider
Jeffrey Olliffe, M.D.
Seattle Sperm Bank
4915 25th Avenue NE
Seattle, WA, 98105
Fax: 206-466-4696

Custom Carrier Screen (ECS)

Number of genes tested: 1

SUMMARY OF RESULTS AND RECOMMENDATIONS

⊖ Negative

Negative for all genes tested: *MCCC1*
To view a full list of genes and diseases tested
please see Table 1 in this report

AR=Autosomal recessive; XL=X-linked

Recommendations

- Consideration of residual risk by ethnicity after a negative carrier screen is recommended for the other diseases on the panel, especially in the case of a positive family history for a specific disorder.

Test description

This patient was tested for the genes listed above using one or more of the following methodologies: target capture and short-read sequencing, long-range PCR followed by short-read sequencing, targeted genotyping, and/or copy number analysis. Please note that negative results reduce but do not eliminate the possibility that this individual is a carrier for one or more of the disorders tested. Please view the Table of Residual Risks Based on Ethnicity at the end of this report or at **go.sema4.com/residualrisk** for gene transcripts, sequencing exceptions, specific detection rates, and residual risk estimates after a negative screening result. With individuals of mixed ethnicity, it is recommended to use the highest residual risk estimate. Only known pathogenic or likely pathogenic variants are reported. This carrier screening test does not report likely benign variants and variants of uncertain significance (VUS). If reporting of likely benign variants and VUS are desired in this patient, please contact the laboratory at 800-298-6470, option 2 to request an amended report.

Anastasia Larmore, Ph.D., Assistant Laboratory Director
Laboratory Medical Consultant: George A. Diaz, M.D., Ph.D.

Genes and diseases tested

For specific detection rates and residual risk by ethnicity, please visit **go.sema4.com/residualrisk**

Table 1: List of genes and diseases tested with detailed results

	Disease	Gene	Inheritance Pattern	Status	Detailed Summary
⊖	Negative				
	3-Methylcrotonyl-CoA Carboxylase Deficiency (*MCCC1*-Related)	*MCCC1*	AR	Reduced Risk (see table below)	

AR=Autosomal recessive; XL=X-linked

Table 2: Residual Risk by ethnicity for negative results

Disease (Inheritance)	Gene	Ethnicity	Carrier Frequency	Detection Rate	Residual Risk	Analytical Detection Rate
3-Methylcrotonyl-CoA Carboxylase Deficiency (MCCC1 -Related) (AR) NM_020166.4	*MCCC 1*	African	1 in 266	51%	1 in 540	99%
		East Asian	1 in 204	37%	1 in 330	
		European (Non-Finnish)	1 in 353	82%	1 in 1,900	
		Native American	1 in 488	91%	1 in 5,100	
		South Asian	1 in 1000	99%	1 in 99,900	
		Worldwide	1 in 423	73%	1 in 1,600	

* Carrier detection by HEXA enzyme analysis has a detection rate of approximately 98% (Applies to *HEXA* gene testing only).
ǂ Carrier frequencies include milder and reduced penetrance forms of the disease. Therefore, carrier frequencies may appear higher than reported in the literature (Applies to *BTD, F9, GJB2, GJB1, GLA,* and *MEFV* gene testing only).
ǂ Please note that *GJB2* testing includes testing for the two upstream deletions, del(GJB6-D13S1830) and del(GJB6-D13S1854) (PMID:11807148 and 15994881) (Applies to *GJB2* gene testing only).
AR: Autosomal recessive; N/A: Not available; XL: X-linked

Test methods and comments

Genomic DNA isolated from this patient was analyzed by one or more of the following methodologies, as applicable:

Next Generation Sequencing (NGS) (Analytical Detection Rate >95%)

NGS was performed on a panel of genes for the purpose of identifying pathogenic or likely pathogenic variants.

Agilent SureSelect™QXT technology was used with a custom capture library to target the exonic regions and intron/exon splice junctions of the relevant genes, as well as a number of UTR, intronic or promoter regions that contain previously reported mutations. Samples were pooled and sequenced on the Illumina HiSeq 2500 platform in the Rapid Run mode or the Illumina NovaSeq platform in the Xp workflow, using 100 bp paired-end reads. The sequencing data was analyzed using a custom bioinformatics algorithm designed and validated in house.

The coding exons and splice junctions of the known protein-coding RefSeq genes were assessed for the average depth of coverage (minimum of 20X) and data quality threshold values. Most exons not meeting a minimum of >20X read depth across the exon are further analyzed by Sanger sequencing. Please note that several genomic regions present difficulties in mapping or obtaining read depth >20X. The exons contained within these regions are noted within Table 1 (as "Exceptions") and will not be reflexed to Sanger sequencing if the mapping quality or coverage is poor. Any variants identified during testing in these regions are confirmed by a second method and reported if determined to be pathogenic or likely pathogenic. However, as there is a possibility of false negative results within these regions, detection rates and residual risks for these genes have been calculated with the presumption that variants in these exons will not be detected, unless included in the MassARRAY® genotyping platform.

This test will detect variants within the exons and the intron-exon boundaries of the target regions. Variants outside these regions may not be detected, including, but not limited to, UTRs, promoters, and deep intronic areas, or regions that fall into the Exceptions mentioned above. This technology may not detect all small insertion/deletions and is not diagnostic for repeat expansions and structural genomic variation. In addition, a mutation(s) in a gene not included on the panel could be present in this patient.

Variant interpretation and classification was performed based on the American College of Medical Genetics Standards and Guidelines for the Interpretation of Sequence Variants (Richards et al, 2015). All potentially pathogenic variants may be confirmed by either a specific genotyping assay or Sanger sequencing, if indicated. Any benign variants, likely benign variants or variants of uncertain significance identified during this analysis will not be reported.

Copy Number Variant Analysis (Analytical Detection Rate >95%)

Large duplications and deletions were called from the relative read depths on an exon-by-exon basis using a custom exome hidden Markov model (XHMM) algorithm. Deletions or duplications determined to be pathogenic or likely pathogenic were confirmed by either a custom arrayCGH platform, quantitative PCR, or MLPA (depending on CNV size and gene content). While this algorithm is designed to pick up deletions and duplications of 2 or more exons in length, potentially pathogenic single-exon CNVs will be confirmed and reported, if detected.

Exon Array (Confirmation method) (Accuracy >99%)

The customized oligonucleotide microarray (Oxford Gene Technology) is a highly-targeted exon-focused array capable of detecting medically relevant microdeletions and microduplications at a much higher resolution than traditional aCGH methods. Each array matrix has approximately 180,000 60-mer oligonucleotide probes that cover the entire genome. This platform is designed based on human genome NCBI Build 37 (hg19) and the CGH probes are enriched to target the exonic regions of the genes in this panel.

Quantitative PCR (Confirmation method) (Accuracy >99%)

The relative quantification PCR is utilized on a Roche Universal Library Probe (UPL) system, which relates the PCR signal of the target region in one group to another. To test for genomic imbalances, both sample DNA and reference DNA is amplified with primer/probe sets that specific to the target region and a control region with known genomic copy number. Relative genomic copy numbers are calculated based on the standard ΔΔCt formula.

Long-Range PCR (Analytical Detection Rate >99%)

Long-range PCR was performed to generate locus-specific amplicons for *CYP21A2* , *HBA1* and *HBA2* and *GBA* . The PCR products were then prepared for short-read NGS sequencing and sequenced. Sequenced reads were mapped back to the original genomic locus and run through the bioinformatics pipeline. If indicated, copy number from MLPA was correlated with the sequencing output to analyze the results. For *CYP21A2* , a certain percentage of healthy individuals carry a duplication of the *CYP21A2* gene, which has no clinical consequences. In cases where two copies of a gene are located on the same chromosome in tandem, only the second copy will be amplified and assessed for potentially pathogenic variants, due to size limitations of the PCR reaction. However, because these alleles contain at least two copies of the *CYP21A2* gene in tandem, it is expected that this patient has at least one functional gene in the tandem allele and this patient is therefore less likely to be a carrier. When an individual carries both a duplication allele and a pathogenic variant, or multiple pathogenic variants, the current analysis may not be able to determine the phase (cis/trans configuration) of the *CYP21A2* alleles identified. Family studies may be required in certain scenarios where phasing is required to determine the carrier status.

Residual Risk Calculations

Carrier frequencies and detection rates for each ethnicity were calculated through the combination of internal curations of >28,000 variants and genomic frequency data from >138,000 individuals across seven ethnic groups in the gnomAD database. Additional variants in HGMD and novel deleterious variants were also incorporated into the calculation. Residual risk values are calculated using a Bayesian analysis combining the *a priori* risk of being a pathogenic mutation carrier (carrier frequency) and the detection rate. They are provided only as a guide for assessing approximate risk given a negative result, and values will vary based on the exact ethnic background of an individual. This report does not represent medical advice but should be interpreted by a genetic counselor, medical geneticist or physician skilled in genetic result interpretation and the relevant medical literature.

Sanger Sequencing (Confirmation method) (Accuracy >99%)

Sanger sequencing, as indicated, was performed using BigDye Terminator chemistry with the ABI 3730 DNA analyzer with target specific amplicons. It also may be used to supplement specific guaranteed target regions that fail NGS sequencing due to poor quality or low depth of coverage (<20 reads) or as a confirmatory method for NGS positive results. False negative results may occur if rare variants interfere with amplification or annealing.

SELECTED REFERENCES

Carrier Screening

Grody W et al. ACMG position statement on prenatal/preconception expanded carrier screening. *Genet Med.* 2013 15:482-3.

Variant Classification:

Richards S et al. Standards and guidelines for the interpretation of sequence variants: a joint consensus recommendation of the American College of Medical Genetics and Genomics and the Association for Molecular Pathology. *Genet Med.* 2015 May;17(5):405-24

Additional disease-specific references available upon request.

myriad WOMEN'S HEALTH

RESULTS RECIPIENT
SEATTLE SPERM BANK
Attn: Jeffrey Olliffe
4915 25th Ave NE Ste 204w
Seattle, WA 98105-5668
Phone: (206) 588-1484
Fax: (206) 466-4696
NPI: 1306838271
Report Date: 09/10/2019

MALE
DONOR 12220
DOB: [redacted]
Ethnicity: Mixed or Other Caucasian
Sample Type: EDTA Blood
Date of Collection: 09/03/2019
Date Received: 09/05/2019
Date Tested: 09/10/2019
Barcode: 11004212718038
Accession ID: CSL4WMFXHFZDVYL
Indication: Egg or sperm donor

FEMALE
N/A

Foresight® Carrier Screen

NEGATIVE

ABOUT THIS TEST

The **Myriad Foresight Carrier Screen** utilizes sequencing, maximizing coverage across all DNA regions tested, to help you learn about your chance to have a child with a genetic disease.

RESULTS SUMMARY

Risk Details	DONOR 12220	Partner
Panel Information	Foresight Carrier Screen Custom Panel 8382 **(2 conditions tested)**	N/A
All conditions tested A complete list of all conditions tested can be found on page 4.	⊖ **NEGATIVE** No disease-causing mutations were detected.	N/A

CLINICAL NOTES

- None

NEXT STEPS

- If necessary, patients can discuss residual risks with their physician or a genetic counselor.

Methods and Limitations

DONOR 12220 [Foresight Carrier Screen]: Sequencing with copy number analysis.

Sequencing with copy number analysis

High-throughput sequencing and read depth-based copy number analysis are used to analyze the listed exons, as well as selected intergenic and intronic regions, of the genes in the Conditions Tested section of the report. The region of interest (ROI) of the test comprises these regions, in addition to the 20 intronic bases flanking each exon. In a minority of cases where genomic features (e.g., long homopolymers) compromise calling fidelity, the affected intronic bases are not included in the ROI. The ROI is sequenced to high coverage and the sequences are compared to standards and references of normal variation. More than 99% of all bases in the ROI are sequenced at greater than the minimum read depth. Mutations may not be detected in areas of lower sequence coverage. Small insertions and deletions may not be as accurately determined as single nucleotide variants. Genes that have closely related pseudogenes may be addressed by a different method. *CFTR* and *DMD* testing includes analysis for both large (exon-level) deletions and duplications with an average sensitivity of 99%, while other genes are only analyzed for large deletions with a sensitivity of >75%. However, the sensitivity may be higher for selected founder deletions. The breakpoints of copy number variants and exons affected are estimated from probe positions. Only exons known to be included in the copy number variant are provided in the name. In some cases, the copy number variant may be larger or smaller than indicated. If *GJB2* is tested, two large upstream deletions which overlap *GJB6* and affect the expression of *GJB2*, del(*GJB6*-D13S1830) and del(*GJB6*-D13S1854), are also analyzed. Mosaicism or somatic variants present at low levels may not be detected. If detected, these may not be reported.

Detection rates are determined by using literature to estimate the fraction of disease alleles, weighted by frequency, that the methodology is unable to detect. Detection rates only account for analytical sensitivity and certain variants that have been previously described in the literature may not be reported if there is insufficient evidence for pathogenicity. Detection rates do not account for the disease-specific rates of de novo mutations.

All variants that are a recognized cause of the disease will be reported. In addition, variants that have not previously been established as a recognized cause of disease may be identified. In these cases, only variants classified as "likely" pathogenic are reported. Likely pathogenic variants are described elsewhere in the report as "likely to have a negative impact on gene function". Likely pathogenic variants are evaluated and classified by assessing the nature of the variant and reviewing reports of allele frequencies in cases and controls, functional studies, variant annotation and effect prediction, and segregation studies. Exon level duplications are assumed to be in tandem and are classified according to their predicted effect on the reading frame. Benign variants, variants of uncertain significance, and variants not directly associated with the intended disease phenotype are not reported. Curation summaries of reported variants are available upon request.

Limitations

In an unknown number of cases, nearby genetic variants may interfere with mutation detection. Other possible sources of diagnostic error include sample mix-up, trace contamination, bone marrow transplantation, blood transfusions and technical errors. This test is designed to detect and report germline alterations. While somatic variants present at low levels may be detected, these may not be reported. If more than one variant is detected in a gene, additional studies may be necessary to determine if those variants lie on the same chromosome or different chromosomes. The test does not fully address all inherited forms of intellectual disability, birth defects and genetic disease. A family history of any of these conditions may warrant additional evaluation. Furthermore, not all mutations will be identified in the genes analyzed and additional testing may be beneficial for some patients. For example, individuals of African, Southeast Asian, and Mediterranean ancestry are at increased risk for being carriers for hemoglobinopathies, which can be identified by CBC and hemoglobin electrophoresis or HPLC (*ACOG Practice Bulletin No. 78. Obstet.Gynecol. 2007;109:229-37*).

This test was developed and its performance characteristics determined by Myriad Women's Health, Inc. It has not been cleared or approved by the US Food and Drug Administration (FDA). The FDA does not require this test to go through premarket review. This test is used for clinical purposes. It should not be regarded as investigational or for research. This laboratory is certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as qualified to perform high-complexity clinical testing. These results are adjunctive to the ordering physician's evaluation. CLIA Number: **#05D1102604**.

Resources

GENOME CONNECT | http://www.genomeconnect.org

Patients can share their reports via research registries such as Genome Connect, an online research registry working to build the knowledge base about genetics and health. Genome Connect provides patients, physicians, and researchers an opportunity to share genetic information to support the study of the impact of genetic variation on health conditions.

RESULTS RECIPIENT
SEATTLE SPERM BANK
Attn: Jeffrey Olliffe
NPI: 1306838271
Report Date: 09/10/2019

MALE
DONOR 12220
DOB: [redacted]
Ethnicity: Mixed or Other Caucasian
Barcode: 11004212718038

FEMALE
N/A

SENIOR LABORATORY DIRECTOR

Jack Ji, PhD, FACMG

Report content approved by Jack Ji, PhD, FACMG on Sep 11, 2019

Conditions Tested

COL4A3-related Alport Syndrome - **Gene:** COL4A3. Autosomal Recessive. Sequencing with copy number analysis. **Exons:** NM_000091:1-52. **Detection Rate:** Mixed or Other Caucasian 97%.

USH2A-related Disorders - **Gene:** USH2A. Autosomal Recessive. Sequencing with copy number analysis. **Exons:** NM_206933:2-72. **Detection Rate:** Mixed or Other Caucasian 94%.

Risk Calculations

Below are the risk calculations for all conditions tested. Since negative results do not completely rule out the possibility of being a carrier, the **residual risk** represents the patient's post-test likelihood of being a carrier and the **reproductive risk** represents the likelihood the patient's future children could inherit each disease. These risks are inherent to all carrier screening tests, may vary by ethnicity, are predicated on a negative family history and are present even after a negative test result. Inaccurate reporting of ethnicity may cause errors in risk calculation. The reproductive risk presented is based on a hypothetical pairing with a partner of the same ethnic group.

Disease	DONOR 12220 Residual Risk	Reproductive Risk
COL4A3-related Alport Syndrome	1 in 6,200	< 1 in 1,000,000
USH2A-related Disorders	1 in 2,200	< 1 in 1,000,000

TO: ATTN:Seattle Sperm Bank

Integrated GENETICS
LabCorp Specialty Testing Group

Client/Sending Facility:
Seattle Sperm Bank

4915 25th Ave Ne Ste 204
SEATTLE, WA 98105
Ph: (206)588-1484
Fax: (206) 466-4696 WAB-55

LCLS Specimen Number:	**250-129-1195-0**	Account Number:	46857540
Patient Name:	**12220, DONOR**	Ordering Physician:	**J OLLIFFE**
Date of Birth:	[redacted]	Specimen Type:	**BLOOD**
Gender:	M	Client Reference:	
Patient ID:		Date Collected:	09/07/2017
Lab Number:	(J17-3359 L	Date Received:	09/08/2017
Indications:	DONOR	Date Reported:	**09/29/2017**
Test:	**Chromosome, Blood, Routine**		
Cells Counted:	15	Cells Karyotyped:	2
Cells Analyzed:	5	Band Resolution:	550

CYTOGENETIC RESULT: 46,XY

INTERPRETATION: NORMAL MALE KARYOTYPE

Cytogenetic analysis of PHA stimulated cultures has revealed a MALE karyotype with an apparently normal GTG banding pattern in all cells observed.

This result does not exclude the possibility of subtle rearrangements below the resolution of cytogenetics or congenital anomalies due to other etiologies.

Chromosome analysis performed by Dianon Pathology CLIA 07D0644713. 1 Forest Parkway Shelton CT, 06484. Laboratory Director, James B Amberson, MD.

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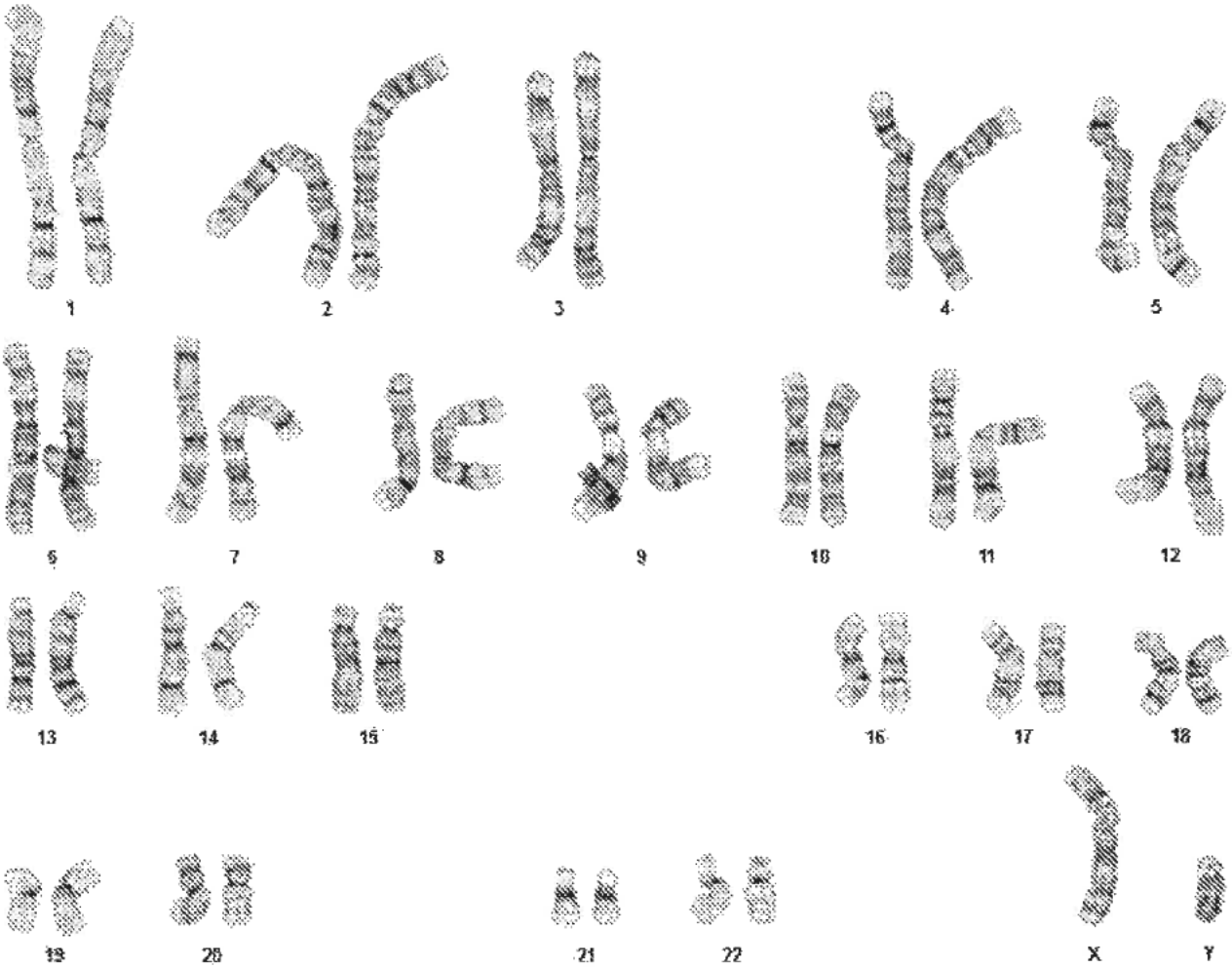
LCLS Specimen Number:	**250-129-1195-0**
Patient Name:	**12220, DONOR**
Date of Birth:	[redacted]
Gender:	M
Patient ID:	
Lab Number:	(J17-3359 L

Account Number:	46857540
Ordering Physician:	**J OLLIFFE**
Specimen Type:	**BLOOD**
Client Reference:	
Date Collected:	09/07/2017
Date Received:	09/08/2017



TO: ATTN:Seattle Sperm Bank

Integrated GENETICS
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LCLS Specimen Number:	**250-129-1195-0**	Account Number:	46857540
Patient Name:	**12220, DONOR**	Ordering Physician:	**J OLLIFFE**
Date of Birth:	[redacted]	Specimen Type:	**BLOOD**
Gender:	M	Client Reference:	
Patient ID:		Date Collected:	09/07/2017
Lab Number:	(J17-3359 L	Date Received:	09/08/2017

Hiba Risheg, PhD., FACMG

Patricia Kandalaft, MD
Medical Director
Peter Papenhausen, PhD
National Director of Cytogenetics

Technical component performed by Laboratory Corporation of America Holdings, 550 17th Ave. Suite 200 , SEATTLE , WA , 98122-5789 (800) 676-8033

Professional Component performed by LabCorp/Dynacare CLIA 50D0632567, 550 17th Ave. Suite 200, Seattle WA 98122-5789. Medical Director, Patricia Kandalaft, MD
Integrated Genetics is a brand used by Esoterix Genetic Laboratories, LLC, a wholly-owned subsidiary of Laboratory Corporation of America Holdings.

TO: ATTN:Seattle Sperm Bank

LabCorp Laboratory Corporation of America

Patient Report

Patient: 12220, DONOR
DOB: [redacted] **Patient ID:** **Control ID:** B0064740894
Specimen ID: 250-129-1196-0
Date collected: 09/07/2017 1015 Local

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
					01
Hemoglobin Fractionation					01
Hgb F	0.0		%	0.0 - 2.0	02
Hgb A	97.4		%	94.0 - 98.0	02
Hgb S	0.0		%	0.0	02
Hgb C	0.0		%	0.0	02
Hgb A2	2.6		%	0.7 - 3.1	02
Interpretation					
Normal adult hemoglobin present.					02
					01
Serology/Immunology					01
Rh Factor	Positive				01
Please note: Prior records for this patient's ABO / Rh type are not available for additional verification.					
					01
CBC, Platelet Ct, and Diff					01
WBC	3.7		x10E3/uL	3.4 - 10.8	01
RBC	4.72		x10E6/uL	4.14 - 5.80	01
Hemoglobin	14.2		g/dL	12.6 - 17.7	01
Hematocrit	42.4		%	37.5 - 51.0	01
MCV	90		fL	79 - 97	01
MCH	30.1		pg	26.6 - 33.0	01
MCHC	33.5		g/dL	31.5 - 35.7	01
RDW	12.7		%	12.3 - 15.4	01
Platelets	**132**	**Low**	x10E3/uL	150 - 379	01
Neutrophils	48		%		01
Lymphs	38		%		01
Monocytes	11		%		01
Eos	3		%		01
Basos	0		%		01
Neutrophils (Absolute)	1.7		x10E3/uL	1.4 - 7.0	01
Lymphs (Absolute)	1.4		x10E3/uL	0.7 - 3.1	01
Monocytes(Absolute)	0.4		x10E3/uL	0.1 - 0.9	01
Eos (Absolute)	0.1		x10E3/uL	0.0 - 0.4	01
Baso (Absolute)	0.0		x10E3/uL	0.0 - 0.2	01
Immature Granulocytes	0		%		01
Immature Grans (Abs)	0.0		x10E3/uL	0.0 - 0.1	01
					01
Urinalysis Gross Exam					01
Specific Gravity	1.020			1.005 - 1.030	01
pH	6.5			5.0 - 7.5	01
Urine-Color	Yellow			Yellow	01
Appearance	**Cloudy Abnormal**			Clear	01

13 Sept 17