



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: 06/04/2020

MALE
DONOR 12333
 DOB: ██████████
 Ethnicity: Mixed or Other
 Caucasian
 Sample Type: EDTA Blood
 Date of Collection: 05/27/2020
 Date Received: 05/29/2020
 Date Tested: 06/04/2020
 Barcode: 11004512620238
 Accession ID:
 CSLYMF23WM6LZ6G
 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 12333	Partner
Panel Information	Foresight Carrier Screen Reflex Panel (F11) (1 condition tested)	N/A
<p>All conditions tested</p> <p>A complete list of all conditions tested can be found on page 4.</p>	<p><input type="checkbox"/> NEGATIVE</p> <p>No disease-causing mutations were detected.</p>	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 12333 [Foresight Carrier Screen]: Sequencing with copy number analysis (DTS v3.1).

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 (Genome Reference Consortium Human Build 37 (GRCh37)/hg19). 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. This test is not designed to detect sex chromosome copy number variations. If present, sex chromosome abnormalities may significantly reduce test sensitivity for X-linked conditions. Residual and reproductive risks provided assume a normal karyotype. Risks for individuals with abnormal karyotypes may be different. 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>



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Barcode: 11004512620238

FEMALE
N/A

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.

SENIOR LABORATORY DIRECTOR

A handwritten signature in black ink that reads "Jack Ji".

Jack Ji, PhD, FACMG

Report content approved by Jack Ji, PhD, FACMG on Jun 5, 2020



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Conditions Tested

Factor XI Deficiency - Gene: F11. Autosomal Recessive. Sequencing with copy number analysis. Exons: NM_000128:2-15. Detection Rate: Mixed or Other Caucasian >99%.



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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 12333 Residual Risk	Reproductive Risk
Factor XI Deficiency	< 1 in 50,000	< 1 in 1,000,000