LABORATORY FOR MOLECULAR MEDICINE

CLIA# 22D1005307

Center for Genetics and Genomics
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PARTNERS HEALTHCARE

HARVARD MEDICAL SCHOOL

The LMM is a satellite facility of Massachusetts General Hospital.

Specimen type(s):

☐ Blood ☐ DNA ☐ Other: ______________________ Date Collected: ______________ (MM-DD-YYYY)

REFERRING PHYSICIAN INFORMATION

First Name	MI	Last Name	Provider UPIN#	Speciality:
			Email:	
Phone:	Fax:		Contact if different from referring physician (e.g.genetic counselor) Please include name and phone/email:	
Institution:				
Address:				
			Fax duplicate report to (attach additional sheet if needed):	
City:	State:			
Zip Code:	Country:			

PATIENT INFORMATION

First Name	MI	Last Name	Institution:	
			Medical Record #:	
Phone:				
Email:			Is the patient adopted? ☐ Yes ☐ No	
			Is patient deceased? ☐ Yes ☐ No If yes, at what age?	
Address:			DOB (MM-DD-YYYY): __ __ - __ __ - __ __ __ __	Gender: ☐ Male ☐ Female ☐ Unknown
City:	State:			
Zip Code:	Country:			

Race: (optional)
☐ American Indian or Alaska Native
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ Asian
☐ Caucasian
(Check all that apply)

Ethnicity: (optional)
Hispanic ☐ Yes ☐ No
Ashkenazi Jewish ☐ Yes ☐ No
Other: ______________
(Check all that apply)

PAYMENT INFORMATION

☐ **Referring Facility:** ________________________________

Bill to name: ______________________ and/or Department: ______________________

Facility address: ________________________________

Contact name: ______________________ Phone number: ______________________

Purchase order number: ________________________________

☐ **Patient Pay:** ☐ Credit card ☐ Check (Test will not be performed until payment is received.)

Name (as it appears on credit card): ______________________ Expiration Date: __________

Credit card type: ☐ Mastercard ☐ Visa ☐ AMEX

Credit card number: ______________________ 3 Digit Security Code: __________

How did you hear about our lab? ☐ Internet Site: __________ ☐ Colleague __________
☐ Conference: __________ ☐ Other: __________

ALL TESTS ALSO REQUIRE A SPECIFIC GENE TEST FORM AND INFORMED CONSENT.

SAMPLE REQUIREMENTS:
The preferred blood specimen is a 7 ml blood sample (3-5ml for infants) collected in a lavender top (K_3EDTA) blood tube. Smaller blood samples or other tissue specimens may also be acceptable for certain tests. Please contact the laboratory for more details.

SHIPPING SAMPLES:
Each sample must be accompanied by a requisition form (available at http://www.hpcgg.org/LMM/forms.html). Please ensure that all samples are labeled with the patient's name and date of birth. All genetic tests require informed consent. Please have the patient (or parent) read and sign the consent form below.

The blood sample (with forms) should be shipped overnight at room temperature to:

Laboratory for Molecular Medicine
Attention: Clinical Laboratory
65 Landsdowne Street
Cambridge, MA 02139

For more detailed information about shipping procedures, see our website http://www.hpcgg.org/lmm/.

INFORMED CONSENT:

I understand that:

1) The purpose of this test is to determine if I/my child may have a mutation in the gene(s) being tested, which has been found to be associated with this condition.
2) Genetic counseling is available to me if I desire further information about this condition.
3) Except in the case of a known mutation test, a negative genetic test result does not rule out a diagnosis of, a predisposition towards, or the ability to pass on this condition but diminishes the likelihood that this gene is involved.
4) This genetic test is specific for the indication for testing and does not test for other conditions. Therefore, a negative result does not guarantee my/my child's health
5) In some families, genetic testing might discover non-paternity, or some other previously unknown information about family relationships, such as adoption.
6) The testing process includes highly skilled technicians and advanced technology. Although the method is extremely reliable, as in any laboratory, there is a small possibility that the test will not work properly, or an error may occur.
7) The lab will make every attempt to report results in the indicated turn-around time but cannot accept responsibility for delays.
8) My results will be given to my healthcare provider who will discuss them with me.
9) If this test requisition form is incomplete, and my health care provider cannot provide the information, I understand that it may be necessary for lab staff to contact me directly to obtain or verify the information needed to complete the form.

I have been informed and agree that my ordering provider will receive the results of my genetic tests.

If my ordering provider is within **Partners HealthCare System**, I understand that my results will also become part of my permanent medical record. If this genetic test is for diagnostic purposes (condition which I am currently showing signs and symptoms) others may be able to view these test results as described in the
Partners HealthCare Notice for Use and Sharing of Protected Health Information
(http://intranet.partners.org/finance/hipaa/Privacy/1/1_PH122_EngVer.pdf).
If this genetic test is for screening purposes (condition which I am not showing signs or symptoms) the test results will only be accessible within my record by my ordering provider.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do hereby consent to provide a specimen for testing.

____
Name of patient (please print)

____
Signature (Patient or patient's legal representative) Date

____
Signature (Physician) Date

Please note: A physician may sign this form in lieu of the patient if prior written consent has been obtained from the patient and if testing is for diagnostic purposes only.

HEARING LOSS GENE SPECIFIC REQUISITION FORM

Name: ____

DOB: _____ / _____ / __________ **(MM/DD/YYYY)**

GENE TEST(S) TO BE PERFORMED:

Check box(es) to order testing. For reflex testing, indicate order in space provided (e.g. 1, 2, 3)

- ___ ☐ **Connexin 26 Gene Sequencing Test (*GJB2;* Recessive and Dominant Hearing Loss)**
- ___ ☐ ***GJB6*-D13S1830 (Connexin 30) Deletion Test (Recessive Hearing Loss)**
- ___ ☐ **Mitochondrial Gene Panel: *12SrRNA* and *tRNAser(UCN)* (Congenital or Late-onset Hearing Loss)**
- ___ ☐ **PDS Gene Sequencing Test (Hearing Loss with EVA or Pendred Syndrome)**
- ___ ☐ ***MYO7A* Gene Sequencing Test (Usher Syndrome or Hearing Loss with Delayed Walking)**
- ___ ☐ ***OTOF* Gene Sequencing Test (Recessive Hearing Loss and/or Auditory Neuropathy/Dys-Synchrony)**
- ___ ☐ ***COCH* Gene Sequencing Test (Progressive Hearing Loss with Vestibular Dysfunction)**
- ___ ☐ ***POU3F4* Gene Sequencing Test (X-linked hearing Loss with Perilymphatic Gusher)**
- ___ ☐ **Familial Mutation Test** (Indicate gene, mutation, and information on proband (1st person tested) below)

Gene____________________ Mutation_____________________________

Proband Name_________________________ LMM Accession #: PM-______________ Relationship ___________

PURPOSE OF STUDY

Clinical status: ☐ Symptomatic ☐ Asymptomatic

Purpose of study: ☐ Diagnostic ☐ Carrier Screen ☐ Other _______________________________

Age of onset of hearing loss:________ **ICD-9 Code:** ☐ 389.1 (sensorineural hearing loss) ☐ Other____________

Type of hearing loss: ☐ Sensorineural ☐ Conductive ☐ Mixed **Laterality:** ☐ Unilateral ☐ Bilateral

Severity (PTA):

Left Ear: ☐ Mild (15-30dB) ☐ Moderate (31-50dB) ☐ Moderately-severe (51-70dB) ☐ Severe (71-90dB) ☐ Profound (>90db)

Right Ear: ☐ Mild (15-30dB) ☐ Moderate (31-50dB) ☐ Moderately-severe (51-70dB) ☐ Severe (71-90dB) ☐ Profound (>90db)

Audiogram Shape:

Left Ear: ☐ Flat (all frequencies) ☐ Sloping (high frequency) ☐ Saucer-shaped (mid frequency) ☐ Rising (low frequency)

Right Ear: ☐ Flat (all frequencies) ☐ Sloping (high frequency) ☐ Saucer-shaped (mid frequency) ☐ Rising (low frequency)

Progression: ☐ Stable ☐ Progressive ☐ Fluctuating ☐ Unknown

Vestibular problems: ☐ None ☐ Delayed walking ☐ Dizziness, vertigo, balance problems ☐ Unknown

Temporal bone abnormalities on CT/MRI: ☐ None ☐ Unknown ☐ EVA ☐ Mondini dysplasia
☐ Other - explain:_____________________________

Stapes fixation: ☐ Yes ☐ No **Perilymphatic gusher with stapedectomy:** ☐ Yes ☐ No

Exposure to aminoglycoside antibiotics (e.g gentamicin, neomycin, tobramycin, amikacin): ☐ Yes ☐ No ☐ Unknown

Eye Findings: ☐ None ☐ Unknown ☐ Retinitis Pigmentosa ☐ Other - explain:_____________________________

Other relevant medical problems: ____

Sibling with or other family history of similar hearing loss ☐ Yes ☐ No

List affected individuals: ____

____

(Sketch below or attach pedigree if appropriate)

Has another family member already had genetic testing for this disease? ☐ Yes ☐ No

If yes, please describe in the comments section and attach a copy of the genetic test lab report and pedigree.

Comments/Special Instructions:

Pedigree:

Standard Symbols:

○ = Female	■ ● ◆ = Affected individual
□ = Male	⊙ = Carrier
◇ = Gender unknown	

Ethnicity

Paternal side: ____________________

Maternal side: ____________________

Consanguinity? ☐ Yes ☐ No

Other: ____________________