

**LABORATORY FOR MOLECULAR MEDICINE**

CLIA# 22D1005307

Center for Genetics and Genomics

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**PARTNERS**  
HEALTHCAREHARVARD  
MEDICAL SCHOOL

The LMM is a satellite facility of Massachusetts General Hospital.

**Specimen type(s):**

(MM-DD-YYYY)

 Blood DNA Other: \_\_\_\_\_

Date Collected: \_\_\_\_\_

**REFERRING PHYSICIAN INFORMATION**

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

**PATIENT INFORMATION**

First Name	MI	Last Name	Institution:	
			Medical Record #:	
Phone:				
Email:	Is the patient adopted?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Is patient deceased?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Address:		If yes, at what age?		
		DOB (MM-DD-YYYY):	Gender:	
City:	State:	_____ - _____ - _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Zip Code:	Country:		<input type="checkbox"/> Unknown	

<b>Race:</b> (optional)	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<b>Ethnicity:</b> (optional) Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Caucasian		Ashkenazi Jewish <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander			Other: _____
(Check all that apply)			(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.**



# REQUISITION FORM

FAMILIAL ADENOMATOUS POLYPOSIS (FAP) AND HEREDITARY NON-POLYPOSIS COLORECTAL CANCER (HNPCC)

Name: \_\_\_\_\_

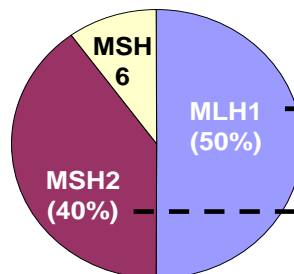
DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM/DD/YYYY)

## HNPCC GENE TESTS

Reflex ?  Yes  No  
(If yes, indicate order below)

- ↓
- \_\_\_\_\_  *MLH1* Full Gene Sequencing
  - \_\_\_\_\_  *MSH2* Full Gene Sequencing
  - \_\_\_\_\_  *MSH6* Full Gene Sequencing
  - \_\_\_\_\_  *MLH1* Deletion/Duplication (MLPA)
  - \_\_\_\_\_  *MSH2* Deletion/Duplication (MLPA)

Mutation Spectrum  
(Point Mut + Del/Dup)



Mutation Detection Rate

- 50-80% SEQU  
5-10% DEL/DUP
- 90-95 % SEQU  
17-50 % DEL/DUP

### HNPCC Familial Known Mutation Test

Gene \_\_\_\_\_ Proband's Accession# \_\_\_\_\_  
Mutation \_\_\_\_\_ Patient's Relationship to Proband \_\_\_\_\_

Peltomaki et al (2003); www.genetests.org

## FAP GENE TESTS

Reflex ?  Yes  No   
(If yes, indicate order below)

- ↓
- \_\_\_\_\_  *APC* Full Gene Sequencing (~ 90% of *APC* mutations)
  - \_\_\_\_\_  *APC* Deletion/Duplication (MLPA) (~ 10% of *APC* mutations)

### APC Familial Known Mutation Test

Mutation \_\_\_\_\_ Proband's Accession# \_\_\_\_\_  
Patient's Relationship to Proband \_\_\_\_\_

## PURPOSE OF STUDY

**Clinical Diagnosis**  HNPCC  FAP  Attenuated FAP  Unaffected  
 Gardner syndrome  Turcot Syndrome  Muir Torre Syndrome  Unknown

Age at Diagnosis: \_\_\_\_\_ ICD-9 Code(s): \_\_\_\_\_

Meets Clinical Diagnostic Criteria  Yes  No

If yes, which criteria are met? \_\_\_\_\_

Microsatellite Instability (MSI) analysis performed?

- Yes  No
- MSI High  MSI low  MSI Stable

Immunohistochemistry (IHC) performed?  Yes  No

- MLH1* negative  *MSH6* negative
- MSH2* negative  *PMS2* negative

### Clinical Manifestations:

*Colon polyps*  Yes  No #: \_\_\_\_\_ *Colon cancer*  Yes  No Age of onset: \_\_\_\_\_

Other: \_\_\_\_\_

Family history:  Yes  No List affected family members, their clinical features, and relationship to this patient here or on the attached form:

\_\_\_\_\_  
\_\_\_\_\_

**Pedigree:**

**Standard Symbols:**

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

**Ethnicity**

Paternal side: \_\_\_\_\_

Maternal side: \_\_\_\_\_

**Consanguinity?**     Yes     No

**Other:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_