

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#
Phone:	Fax:		Contact if different from referring physician (e.g.genetic counselor) Please include name and phone/email:
Email:			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		
Address:			Is patient deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No
			If yes, at what age?
City:	State:	DOB (MM-DD-YYYY):	Gender:
Zip Code:	Country:	_____ - _____ - _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
			<input type="checkbox"/> Unknown

Race: (optional)	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	Ethnicity: (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

<input type="checkbox"/> Internal:	<input type="checkbox"/> BWH Provider	<input type="checkbox"/> MGH Provider
<input type="checkbox"/> Referring Facility:	_____	
Bill to name:	_____	and/or Department: _____
Facility address:	_____	
Contact name:	_____	Phone number: _____
Purchase order number:	_____	
<input type="checkbox"/> Patient Pay:	<input type="checkbox"/> Credit card	<input type="checkbox"/> Check (Test will not be performed until payment is received.)
Name (as it appears on credit card):	_____	Expiration Date: _____
Credit card type:	<input type="checkbox"/> Mastercard	<input type="checkbox"/> Visa <input type="checkbox"/> AMEX
Credit card number:	_____	3 Digit Security Code: _____

How did you hear about our lab?	<input type="checkbox"/> Internet Site: _____	<input type="checkbox"/> Colleague: _____
	<input type="checkbox"/> Conference: _____	<input type="checkbox"/> 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 (K₃EDTA) 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>). 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) Your results will be given to your healthcare provider who will discuss them with you.

For patients whose referring healthcare provider is outside Partners HealthCare System, the results of the genetic testing will be released only to that provider. For patients within Partners HealthCare System, the results of the genetic testing will be provided to the referring provider and maintained in your medical record; for additional information please refer to the Partners HealthCare Notice for Use and Sharing of Protected Health Information.

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

Please note: Physician may sign this form in lieu of patient if consent has been obtained AND if testing is for diagnostic purposes.

RESEARCH OPPORTUNITIES

Is this patient interested in participating in related research studies? Yes No

May the patient be contacted directly by the Laboratory for Molecular Medicine for these research studies? Yes No

If yes, patient/guardian should sign here: _____ Date: _____

**NOONAN, LEOPARD, CARDIO-FACIO-CUTANEOUS (CFC), COSTELLO
GENE SPECIFIC REQUISITION FORM**

Name: _____

DOB: ____ / ____ / ____ (MM/DD/YYYY)

GENE TEST TO BE PERFORMED:

PTPN11 Full Gene Test (Noonan and LEOPARD Syndromes)

Reflex to *KRAS* Gene Test if negative for *PTPN11* Gene Test (Noonan Syndrome)

KRAS Full Gene Test (Noonan Syndrome)

BRAF Full Gene Test (Cardio-Facial-Cutaneous Syndrome)

Reflex to *KRAS* Gene Test if negative for *BRAF* Gene Test (Cardio-Facio-Cutaneous Syndrome)

HRAS Partial Gene Test- exon 2 only (Costello Syndrome)

Reflex to *HRAS* Full Gene Test (exons 3, 4, 5, 6) if negative for exon 2 (Costello syndrome)

Known Mutation Test: Indicate Gene and Mutation Here _____

PURPOSE OF STUDY

Clinical status: Symptomatic Asymptomatic

Purpose of study: Diagnostic Carrier Screen Presymptomatic Prenatal

Other _____

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.

Clinical diagnosis: _____

ICD-9 Codes: 759.89 (Noonan/LEOPARD)

Age at diagnosis: _____

759.8 (Other specified abnormalities)

Other _____

Congenital heart defect:

Pulmonic valve stenosis

Hypertrophic cardiomyopathy

Septal defect

Other _____

Facial dysmorphism:

Epicanthal folds

Ptosis of the eyelids

Low nasal bridge

Hypertelorism

Downward eye slant

Low set ears and posteriorly rotated

Papillomas

Coarseness

Short stature:

Yes

No

Cognitive development:

Learning disabilities

Developmental delay

Mental retardation

Normal

Skeletal:

Pectus excavatum

Pectus carinatum

Scoliosis

Genitourinary:

Cryptorchidism (undescended testes)

Kidney malformation

If yes, please describe: _____

Bleeding diathesis:

Yes

No

If yes, please describe: _____

Hair/Skin findings:

Yes

No

If yes, please describe: _____

Malignancy:

Yes

No

If yes, please describe: _____

Other: _____

Family history :

Yes

No

List affected individuals: _____

(Sketch on back or attach pedigree if appropriate)

Comments/Special Instructions:

Pedigree:

Standard Symbols:

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

Ethnicity

Paternal side: _____

Maternal side: _____

Consanguinity?

Yes No

Other:
