

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#	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?		<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	

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

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 (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>). 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
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) 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.
- 9) I give permission to be contacted directly concerning research studies for the condition for which I am being tested. These studies may involve one or more of the following: 1) A request for additional clinical records about my condition, 2) Giving permission for my remaining sample to be included in studies looking for other causes or modifiers of this condition, 3) Learning about opportunities to be included in studies on newly developed treatments for my condition.

I do NOT give permission to be contacted directly about any research studies. _____ (Initial)

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

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 consent has been obtained from the patient and if testing is for diagnostic purposes only.

CARDIOVASCULAR GENE SPECIFIC REQUISITION FORM

Name (First Last): _____ DOB: ____ / ____ / ____ (MM/DD/YYYY)

DISEASE SPECIFIC GENE SEQUENCING PANELS:

Prices

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

Hypertrophic Cardiomyopathy (HCM)

_____ HCM CardioChip (*MYH7, MYBPC3, TNNT2, TNNI3, TPM1, ACTC, MYL2, MYL3, LAMP2, PRKAG2, GLA*) \$3,000 Lab Code
Imp-HCMD

Glycogen Storage Cardiac Hypertrophy

_____ Unexplained Cardiac Hypertrophy Panel (*LAMP2, PRKAG2*) \$1,500 Imp-UCHA
 _____ *GLA* Gene Test \$700 Imp-UCHB
 _____ *TTR* (Transthyretin) Gene Test \$485 Imp-TTR-a

Dilated Cardiomyopathy (DCM)

_____ DCM Panel A (*MYH7, MYBPC3, TNNT2, TNNI3, TPM1*) \$3,000 Imp-DCMA
 _____ DCM Panel B (*LMNA, ACTC, PLN, LDB3, TAZ*) \$1,750 Imp-DCMB

Arrhythmogenic Right Ventricular Dysplasia/Cardiomyopathy (ARVD/C)

_____ ARVD/C Panel (*DSP, DSG2, DSC2, PKP2*) \$3,000 Imp-ARVDA

Fabry Disease

_____ *GLA* Gene Test \$700 Imp-GLA-a

FAMILIAL KNOWN MUTATION TEST

_____ **Familial Mutation Test** (Indicate gene, mutation, and information on proband (1st person tested) below) \$250

Gene _____ Mutation _____ LMM Accession #: PM- _____

Proband Name _____ Relationship To Proband _____

SINGLE GENE SEQUENCING TESTS

Genes included in the HCM CardioChip and DCM Panel A

<input type="checkbox"/> _____ <i>MYH7</i> (Myosin heavy chain 7)	Isolated HCM/DCM	\$1,700	Imp-MYH7-a
<input type="checkbox"/> _____ <i>MYBPC3</i> (Myosin-Binding Protein)	Isolated HCM/DCM	\$1,500	Imp-MYBPC3-a
<input type="checkbox"/> _____ <i>TNNT2</i> (Troponin T2)	Isolated HCM/DCM	\$1,000	Imp-TNNT2-a
<input type="checkbox"/> _____ <i>TNNI3</i> (Troponin I)	Isolated HCM/DCM	\$700	Imp-TNNI3-a
<input type="checkbox"/> _____ <i>TPM1</i> (Tropomyosin)	Isolated HCM/DCM	\$700	Imp-TPM1-a

Genes included in the HCM CardioChip

<input type="checkbox"/> _____ <i>ACTC</i> (Alpha cardiac actin)	Isolated HCM/DCM	\$700	Imp-ACTC-a
<input type="checkbox"/> _____ <i>MYL2</i> (Myosin regulatory light chain)	Isolated HCM	\$700	Imp-MYL2-a
<input type="checkbox"/> _____ <i>MYL3</i> (Myosin essential light chain)	Isolated HCM	\$700	Imp-MYL3-a

Genes included in DCM Panel B

<input type="checkbox"/> _____ <i>LMNA</i> (Lamin A/C)	Isolated DCM +/- conduction system disease	\$700	Imp-LMNA-a
<input type="checkbox"/> _____ <i>PLN</i> (Phospholamban)	Isolated DCM	\$250	Imp-PLN-a
<input type="checkbox"/> _____ <i>LDB3</i> (Cypher/ZASP)	Isolated DCM +/- left ventricular non-compaction	\$1,100	Imp-LDB3-a
<input type="checkbox"/> _____ <i>TAZ</i> (Tafazzin)	Isolated DCM/ Barth Syndrome	\$700	Imp-TAZ-a

Genes included in the UCH tests and the HCM CardioChip

<input type="checkbox"/> _____ <i>LAMP2</i> (Lamp Associated Membrane Protein 2)	Danon Disease	\$700	Imp-LAMP2-a
<input type="checkbox"/> _____ <i>PRKAG2</i> (5-AMP-activated protein kinase, γ -2 subunit)	HCM + conduction system defects	\$1,000	Imp-PRKAG2
<input type="checkbox"/> _____ <i>GLA</i> (Alpha-Galactosidase A)	Late onset cardiac hypertrophy/ Fabry disease	\$700	Imp-GLA-a
<input type="checkbox"/> _____ <i>TTR</i> (Transthyretin) Not in HCM CardioChip	Transthyretin Amyloidosis	\$485	Imp-TTR-a

Genes included in the ARVD/C Panel

<input type="checkbox"/> _____ <i>DSP</i> (Desmoplakin)	ARVD/C	\$1,700	Imp-DSP-a
<input type="checkbox"/> _____ <i>DSG2</i> (Desmoglein 2)	ARVD/C	\$1,075	Imp-DSG2-a
<input type="checkbox"/> _____ <i>DSC2</i> (Desmocollin 2)	ARVD/C	\$1,150	Imp-DSC2-a
<input type="checkbox"/> _____ <i>PKP2</i> (Plakophilin 2)	ARVD/C	\$1,500	Imp-PKP2-a

ICD-9 Codes:

425.4: Cardiomyopathy (includes NOS, congestive, constrictive, familial, hypertrophic, idiopathic, nonobstructive, obstructive, restrictive);
425.1: Hypertrophic Obstructive Cardiomyopathy or Hypertrophic subaortic stenosis (idiopathic);
429.3: Cardiomegaly (includes dilatation, hypertrophy; ventricular dilatation);
425.7: Nutritional And Metabolic Cardiomyopathy
425.8: Cardiomyopathy in other disease classified elsewhere
271.0: Glycogenosis (includes Amylopectinosis; Glucose-6-phosphatase deficiency; Glycogen storage disease; McArdle's disease; Pompe's disease; von Gierke's disease;
272.7: Lipidoses (includes Fabry Disease)

