

LABORATORY FOR MOLECULAR MEDICINE

CLIA# 22D1005307

Center for Genetics and Genomics

65 Landsdowne Street

Cambridge, MA 02139-4232

Phone: (617) 768-8500

Fax: (617) 768-8513

**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.

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)
- 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)
- MYO7A* (*USH1B*) Gene Sequencing Test (Usher Syndrome Type 1 or Hearing Loss with Delayed Walking)
- USH2A* Gene Sequencing Test (Usher Syndrome Type 2 or Nonsyndromic RP)
- CLRN1* (*USH3A*) Gene Sequencing Test (Usher Syndrome Type 3)
- Ashkenazi Jewish Common Mutation Panel for Hearing Loss and Usher Syndrome
(167delT & 35delG in Connexin 26, *GJB6-D13S1830* Deletion, R245X in *PCDH15*)
- 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

Auditory neuropathy/dys-synchrony findings: Present OAEs Absent ABR with cochlear microphonic 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: _____

Previous Genetic Testing: No Yes - Gene(s) _____
If variants detected, please elaborate: _____

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: _____

