

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#
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.

Please contact the laboratory prior to sending a sample for prenatal testing at 617-768-8500.

SPECIMEN REQUIREMENTS:

- o Amniocentesis: Direct: at least 10-15cc
- o Cultured: at least one T25 flask

1. A back-up culture should be maintained at an outside facility on both cultured and direct prenatal samples.
2. A 5ml maternal whole blood sample drawn in a lavender top tube (K₃EDTA) must accompany the prenatal sample for the purpose of maternal cell contamination studies. *Please use a separate requisition and consent form for this sample* (<http://www.hpcgg.org/LMM/forms.html>). Please label this sample with mother's name and date of birth.
3. A completed requisition form (<http://www.hpcgg.org/LMM/forms.html>) including date and time of collection must accompany each prenatal sample. Please ensure that all samples are labeled with the mother's name and date of birth. All genetic tests require informed consent. Please have a parent of the fetus read and sign the consent below.

Special Instructions:

If there is a known familial mutation and testing was performed in another lab please send 5 ml of peripheral whole blood drawn in a lavender top tube (K₃EDTA), from the transmitting parent(s) and a copy of the genetic test lab report, along with the prenatal sample. Confirmation of the familial mutation in our lab will help ensure the accuracy of the fetal DNA analysis.

Turn-Around-Time: 2 weeks for known mutation testing. Please contact the lab for information about other tests.

Cost: Please add a surcharge of \$950 to the cost of the test.

SHIPPING SAMPLES:

The prenatal and blood samples (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) 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 written consent has been obtained from the patient and if testing is for diagnostic purposes only.

PRENATAL TEST SPECIFIC REQUISITION FORM

Name: _____

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

GENE TEST TO BE PERFORMED:

Known Mutation(s) Test

Please indicate gene and familial mutation(s) _____

Other Gene Test

Please indicate gene _____

Indication for testing:

PURPOSE OF STUDY

Clinical status: Symptomatic Asymptomatic

Purpose of study: Diagnostic Carrier Screen

Family history : Yes No

List affected individuals: _____

(Sketch pedigree below 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
- = Male
- = Gender unknown
- = Affected individual
- = Carrier

Ethnicity

Paternal side: _____

Maternal side: _____

Consanguinity?

Yes No

Other:

