PARTNERS® HEALTHCARE | PERSONALIZED MEDICINE

The LMM is a satellite facility of Massachusetts General Hospital. • CLIA # 22D1005307

Laboratory for Molecular Medicine

65 Landsdowne Street • Cambridge, MA 02139
Phone: (617) 768-8500 • Fax: (617) 768-8513
www.partners.org/personalizedmedicine/lmm

SPECIMEN INFORMATION

Specimen: ❑ Blood ❑ DNA ❑ Other ____________
❑ Cord Blood* ❑ CVS* ❑ Amnio*
❑ DNA* derived from:
(Choose One) ❑ Cord Blood ❑ CVS ❑ Amnio

Date Collected: (mm/dd/yyyy) ______ / ______ / ____________

Space for Lab Use Only

**Maternal specimen is required to perform Maternal Cell Contamination testing. For MCC sample, complete only the first page of the requisition form to submit with specimen. Note an additional $950 charge will be added for duplicate analysis, MCC studies, internal control tests and rush processing.*

PATIENT INFORMATION

First name: ________________________________ MI: ______

Last name: ______________________________________

Date of Birth: (mm/dd/yyyy) ________ / ________ / ____________

Gender: ❑ Male ❑ Female ❑ Unknown/Unspecified

Is patient pregnant? ❑ No ❑ Yes EDD:__________________

Address: ______________________________________

City: ______________ State: ________ Zip Code: ____________

Phone: ______________________________________

Email: ______________________________________

Institution: ______________________________________

Medical Record Number: ______________________________

Is the patient adopted? ❑ No ❑ Yes

Is the patient deceased? ❑ No ❑ Yes, date:____________

Race and Ethnicity: *Please check **ALL** that apply*

❑ White ❑ Ashkenazi Jewish ❑ Asian
❑ Hispanic ❑ Black/African American
❑ Native Hawaiian or other Pacific Islander
❑ American Indian/Native Alaskan ❑ Other ______________

REFERRING PROVIDER INFORMATION

Referring Provider

Name (First, Last): ______________________________________

Phone: ____________________ Fax: ____________________

Email: ______________________________________

Institution: ______________________________________

Address: ______________________________________

____

City: ______________________________ State: ____________

Zip Code: ____________ Country: ______________________

Genetic Counselor / Additional Contacts

Name (First, Last): ______________________________________

Phone: ____________________ Fax: ____________________

Email: ______________________________________

Institution: ❑ Same as Referring Provider ❑ Provided below

____

____

Place facility sticker here

____

____

PAYMENT INFORMATION

***Please note:** Payment information must be completed for testing to begin.*

❑ **Patient Pay** (please complete section in its entirety)**

❑ **Check** (*please attach to forms*)*

Please make checks payable to **Partners Personalized Medicine**

❑ **Credit card** (*please fill out credit card information in its entirety*)

Card type: ❑ Mastercard ❑ Visa ❑ AMEX

Name (as it appears on card): ______________________________

Credit card number: ______________________________

Expiration Date: ____________ **3 Digit Security Code:** ________

For patient pay, please provide billing address and contact information. If same as above, please note section as such.

❑ **Referring Institution** (please complete section in its entirety)

For new referring facilities, please complete and submit the New Institution Add Form

Bill to Name/Department: ______________________________

Address: ______________________________________

____

City: ______________________________ State: ____________

Zip Code: ______________ Country: ____________________

Phone: ______________________________________

Contact Person: ______________________________________

Patient Pay Billing Address: ______________________________________

City: ______________________ State: ________ Zip Code: __________ Country: ______________________

Home: ______________________ Cell/Work: ______________________ Email: ______________________________

Patient Name: ____ Date of Birth: ______/______/__________ (MM/DD/YYYY)

SPECIMEN & SHIPPING REQUIREMENTS

The preferred blood specimen is a 7 ml blood sample (3-5ml for infants) collected in a lavender top (K_2EDTA or K_3EDTA) blood tube. Smaller blood samples or other tissue specimens may also be acceptable for certain tests. All samples must have two patient identifiers, preferably the patient's name and date of birth. Please contact the laboratory for more details.

Each sample must be accompanied by a requisition form. The ordering provider must sign the declaration 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 requirements and procedures, see our website www.partners.org/personalizedmedicine/lmm.

LABORATORY FOR MOLECULAR MEDICINE POLICIES

By requesting testing from the Laboratory for Molecular Medicine (LMM), the ordering provider indicates that he/she understands AND accepts the policies of the LMM, as noted below, and has communicated these policies to the patient.

1. Our testing process includes highly skilled technicians and advanced technology. As in any laboratory, there is a small possibility that the test will not work properly, or an error may occur.
2. Listed turn around times (TATs) represent the typical TAT for a test, but are not guaranteed.
3. If the requisition form is incomplete, and the healthcare provider cannot provide the required information, lab staff may need to contact patients directly to obtain or verify the information needed to complete the form.
4. Test results, as well as any updates to those results, may become part of a patient's permanent medical record (electronically or otherwise) or be made available (electronically or otherwise) to the ordering healthcare institution and its healthcare team.
5. Results will only be released to the ordering provider and other providers listed on the requisition form. The ordering provider assumes the responsibility to disclose the test results and direct care as appropriate.
6. Test results and submitted clinical information may be shared with other clinical laboratories for the purpose of improving our understanding of the relationship between genetic changes and clinical symptoms. Sharing data in this manner may enable us to provide better interpretations of your genetic findings as well as assist other patients with similar results. We will protect your privacy/confidentiality by removing your name and other direct identifiers, such as SSN or medical record number, from data shared with other laboratories.

RESEARCH POLICIES & OPPORTUNITIES

Blood or other samples sent to the LMM may be used by Partners Healthcare System (PHS), by medical organizations connected to PHS, or by educational or business organizations approved by PHS, for research, education and other activities that support PHS's mission, without your/the patient's specific consent. Other types of research performed in association with the Laboratory for Molecular Medicine require that we obtain consent from the patient (see below).

PATIENTS - Please check off and initial below whether we can contact you to let you know about research studies in which you/your child may be able to participate. These research studies may include:

- A request for additional clinical records about your condition
- Studies to find new causes for your condition
- Studies to evaluate newly developed treatments for your condition

Please check one option: ______ Yes, you can contact me ______ (patient initials)
If yes, please provide your contact information on the first page

______ No, please do not contact me ______ (patient initials)

ORDERING PROVIDER SIGNATURE

I, ____ (print name), as ordering provider, certify that the patient being tested and/or their legal guardian have been informed of the risks, benefits, and limitations of the testing ordered, as well as the policies of the LMM listed above. I have obtained informed consent, as required by my own state and/or federal laws. In addition, I assume responsibility for returning the results of genetic testing to my patient and/or their legal guardian and for ensuring that my patient receives appropriate genetic counseling to understand the implications of their test results.

____

Signature (Ordering Provider) Date

Please Note: A patient consent form is available on our website (www.partners.org/personalizedmedicine/Laboratory-For-Molecular-Medicine/Ordering/Policies) for your convenience and DOES NOT need to be returned to the LMM.

ECTODERMAL DYSPLASIA REQUISITION FORM

Patient Name: ______________________________ Date of Birth: ______/______/__________ (MM/DD/YYYY)

TEST TO BE PERFORMED

Please check box(es) to order. If ordering reflex testing, please indicated order (i.e. 1, 2, 3). Testing can be conducted concurrently if desired.

Hypohidrotic Ectodermal Dysplasia

_____ ❑ *EDA* Gene Sequencing $700

_____ ❑ *EDA* Deletion/Duplication (MLPA) - whole blood sample required $600

Hidrotic Ectodermal Dysplasia 2

_____ ❑ *GJB6* (Connexin 30) Gene Sequencing Test $500

***GJB2* Related-Ectodermal Dysplasias**

_____ ❑ *GJB2* (Connexin 26) Gene Sequencing Test $500

***DSP* Related-Ectodermal Dysplasias/Skin Fragility**

_____ ❑ *DSP* Gene Sequencing Test $1,700

Familial Variant Testing

_____ ❑ Familial Variant(s)** OR ❑ Research Confirmation** $500

If proband testing was performed elsewhere, please attach a copy of the original result and send positive control sample, if available

Gene______________________ Variant______________________________________

Proband Name____

Relationship to Patient__________________ LMM Accession #: PM-__________________

CLINICAL INFORMATION

Clinical status: ❑ Affected ❑ Unknown ❑ Unaffected

Purpose of study: ❑ Diagnostic ❑ Carrier testing ❑ Prenatal ❑ Other ________________________

Clinical diagnosis: ❑ Hypohidrotic Ectodermal Dysplasia ❑ Hidrotic Ectodermal Dysplasis 2

ICD-10 Code(s): ____

Clinical Features:

Sparse hair	❑ Scalp	❑ Body	❑ No	Other features:______________________
Sweat level	❑ Reduced	❑ Absent	❑ Normal	______________________
Hypodontia	❑ Yes → # of permanent teeth______		❑ No	______________________
Conical crowns	❑ Yes		❑ No	______________________

Previous Genetic Testing: ❑ Yes ❑ No Gene(s)/Tests:____________________________________

Result (if variants detected, please elaborate):____________________________________

Has another family member already had genetic testing for this disease? ❑ Yes ❑ No

If yes, please describe and attach a copy of the genetic test lab report and pedigree.

FAMILY HISTORY

Family History: ❑ Yes ❑ No (Sketch below or attach pedigree if appropriate)

Please list affected family members:____________________________________

Paternal Ancestry:________________________

Maternal Ancestry:________________________

Consanguinity: ❑ Yes ❑ No

○ = Female □ = Male ◇ = Gender Unspecified

● ■ ◆ = Affected Individual ⊙ = Carrier

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