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 ($K_2$EDTA or $K_3$EDTA) 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.

# HEARING LOSS REQUISITION FORM

Patient Name: _____ Date of Birth: _____/_____/_____ (MM/DD/YYYY)

## TESTING TO BE PERFORMED

**Check box(es) to order test(s). For reflex testing, indicate order of testing in space provided (i.e. 1, 2, 3).**
**Panels performed via next-generation sequencing (NGS) include CNV analysis. when NGS data meets necessary quality standards.*

### Hearing Loss Tests

____ ❑ Connexin Test: *GJB2* Sequencing and DFNB1 (*GJB6*) Deletions
____ ❑ Connexin Test **REFLEX** to OtoGenome™ Test for Hearing Loss (87 Genes)*
____ ❑ OtoGenome™ Test for Hearing Loss and Related Syndromes (87 Genes)*
*(OtoGenome™ Test related syndromes include Usher, Pendred, Jervell and Lange-Nielsen, Branchio-Oto-Renal, Waardenburg syndromes)*
____ ❑ Mitochondrial Gene Panel: 12SrRNA and tRNAser (UCN)

### Usher Syndrome

____ ❑ Usher Syndrome Panel (11 Genes)*
____ ❑ Remaining OtoGenome™ Genes (Usher Syndrome Panel Reflex)*

### Pendred Syndrome or Hearing Loss with EVA

____ ❑ *SLC26A4* (PDS) Gene Sequencing Test

### Auditory Neuropathy/Dys-synchrony

____ ❑ Auditory Neuropathy Panel (*OTOF* and *DFNB59*)*

### Low Frequency Nonsyndromic Hearing Loss and Wolfram Syndrome

____ ❑ *WFS1* Gene Sequencing Test

### Waardenburg Syndrome

____ ❑ Waardenburg Syndrome Panel (6 Genes)*

### X-linked Hearing Loss with Perilymphatic Gusher

____ ❑ *POU3F4* Gene Sequencing Test

## SINGLE GENE TESTS

**Genes available for Individual Gene Sequencing Tests, please refer to the LMM website.**

### Single Gene Test

____ ❑ _____ Gene Sequencing Test

## FAMILIAL VARIANT TEST

### Familial Variant Testing

(*Sequencing - first 3 variants, $500; each additional variant, $50.)*

____ ❑ Familial Variant(s) OR ❑ Research Confirmation
*(If proband testing was performed elsewhere, please attach a copy of the original result and send positive control sample, if available.)*

Gene #1_____Variant #1_____
Gene #2_____Variant #2_____
Gene #3_____Variant #3_____
Gene #4_____Variant #4_____

Proband Name_____ Relationship to Proband_____

LMM Accession #: PM-_____

**PLEASE PROCEED TO PAGE 4 TO COMPLETE THE FAMILY HISTORY**

# HEARING LOSS REQUISITION FORM

Patient Name: _____ Date of Birth: _____/_____/_____ (MM/DD/YYYY)

## CLINICAL INFORMATION

**Clinical status:** ❑ Affected ❑ Unknown (no screening/evaluation) ❑ Unaffected (all screening/evaluation(s) normal)

**Purpose of study:** ❑ Diagnostic ❑ Carrier testing ❑ Other: _____

**Age at onset of hearing loss:** _____

**ICD-10 Codes:** ❑ H90.5 (unspecified sensorineural hearing loss) ❑ Other _____

**Type of hearing loss:** ❑ Sensorineural ❑ Conductive ❑ Auditory neuropathy/dys-synchrony ❑ Mixed

**Laterality:** ❑ Bilateral ❑ Unilateral

**Progression:** ❑ Stable ❑ Progressive ❑ Fluctuating ❑ Unknown

**Severity (PTA):** **Please attach audiogram if available**

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/frequencies:**

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)

**Exposure to aminoglycoside antibiotics (e.g gentamicin, neomycin, tobramycin, amikacin):** ❑ Yes ❑ No ❑ Unknown

**Auditory neuropathy/dys-synchrony:**
- ❑ No
- ❑ Present OAEs
- ❑ Absent ABR w/ cochlear microphonic
- ❑ Unknown

**BOR features:**
- ❑ None
- ❑ Ear tags
- ❑ Ear abnormalities
- ❑ Branchial arch abnormality
- ❑ Renal abnormality
- ❑ Other (explain):_____

**Electrocardiogram (ECG) finding:**
- ❑ None
- ❑ Long QT
- ❑ Unknown
- ❑ Other (explain): _____

**Eye finding:**
- ❑ None
- ❑ Unknown
- ❑ Retinitis pigmentosa - Age of onset:_____
- ❑ Other (explain): _____

**Temporal bone abnormalities on CT/MRI:**
- ❑ None
- ❑ EVA (enlarged vestibular aqueducts)
- ❑ Mondini dysplasis
- ❑ Unknown
- ❑ Other (explain):_____

**Reproductive:**
- ❑ Delayed puberty
- ❑ Infertility
- ❑ Amenorrhea
- ❑ Ovarian dysgenesis

**Vestibular problems:**
- ❑ None
- ❑ Delayed walking
- ❑ Dizziness/Vertigo
- ❑ Balance problems
- ❑ Unknown

**Waardenburg:**
- ❑ None
- ❑ White forelock
- ❑ Heterochromia
- ❑ Hypoplastic/vivd blue irises
- ❑ Dystopia canthorum
- ❑ Musculoskeletal abnl.
- ❑ Hirschsprung

***POU3F4*-association:**
- ❑ Stapes fixation
- ❑ Perilymphatic gusher

**Previous genetic testing:** ❑ No ❑ Yes - Test/Results:_____

**Other relevant medical problems**: ❑ None ❑ Yes (explain): _____

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

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

## FAMILY HISTORY

**Sibling with or other family history of similar hearing loss?** ❑ Yes ❑ No

List affected individuals and the nature of their hearing loss (Sketch below or attach pedigree if appropriate):_____

_____

_____

Paternal Ancestry:_____

Maternal Ancestry:_____

Consanguinity: ❑ Yes ❑ No

○ = Female □ = Male ◇ = Gender Unspecified

● ■ ◆ = Affected Individual ⊙ = Carrier

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