

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 (K₂EDTA or K₃EDTA) 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 (available at Partners.org/PersonalizedMedicine/Laboratory-For-Molecular-Medicine/Ordering). 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 Partners.org/PersonalizedMedicine/Laboratory-For-Molecular-Medicine/Ordering/Sample-Requirements-Payment-Shipping.

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. The ordering provider can obtain access to your genomic sequence files for the purpose of your clinical care.
7. 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 IRB approved 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 (Partners.org/PersonalizedMedicine/Laboratory-For-Molecular-Medicine/Ordering/Policies) for your convenience and DOES NOT need to be returned to the LMM.
Laboratory for Molecular Medicine • 65 Landsdowne Street • Cambridge, MA, 02139

Phone: 617-768-8500 • Fax: 617-768-8513 • Website: Partners.org/PersonalizedMedicine/Laboratory-For-Molecular-Medicine • Email: Imm@partners.org

Last Revised: 30 Apr 2019

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).

Otogenome Test

___ OtoGenome™ Test for Hearing Loss and Related Syndromes (110 Genes)*

OtoGenome Test is performed via next-generation sequencing (NGS) and includes CNV analysis when NGS data meets necessary quality standards. Includes Usher, Pendred, Jervell and Lange-Nielsen, Branchio-Oto-Renal, Waardenburg, Alport, Alstrom, Muckle-Wells, Deafness Infertility syndromes. This test also encompasses the Connexin Test, Comprehensive DFNB1 and STRC Panel, and STRC only tests listed below.

___ REFLEX to OtoGenome™ Test for Hearing Loss (110 Genes)*

Common Autosomal Recessive Hearing Loss Test

___ Connexin Test: GJB2 Sequencing and DFNB1 (GJB6) Deletion

Pendred Syndrome or Hearing Loss with EVA

___ SLC26A4 (PDS) Gene Sequencing Test

Low Frequency Nonsyndromic Hearing Loss and Wolfram Syndrome

___ WFS1 Gene Sequencing Test

X-linked Hearing Loss with Perilymphatic Gusher

___ POU3F4 Gene Sequencing Test

FAMILIAL VARIANT TEST

Familial Variant Testing

(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

