PARTNERS HEALTHCARE | CENTER FOR PERSONALIZED GENETIC MEDICINE

A TEACHING AFFILIATE OF HARVARD MEDICAL SCHOOL

Patient Healthcare Card Information

LABORATORY FOR MOLECULAR MEDICINE

CLIA# 22D1005307
65 Landsdowne Street
Cambridge, MA 02139-4232
http://pcpgm.partners.org/LMM
Phone: (617) 768-8500
Fax: (617) 768-8513

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 NPI#	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? ☐ Yes ☐ No	
			Is patient deceased? ☐ Yes ☐ No	
Address:			If yes, at what age?	
			DOB (MM-DD-YYYY): __ __ - __ __ - __ __ __ __	Gender: ☐ Male ☐ Female ☐ Unknown
City:	State:			
Zip Code:	Country:			

Race: (Check all that apply)
☐ American Indian or Alaska Native ☐ Asian
☐ Black or African American ☐ Caucasian
☐ Native Hawaiian or Other Pacific Islander

Ethnicity: (Check all that apply)
Hispanic ☐ Yes ☐ No
Ashkenazi Jewish ☐ Yes ☐ No
Other: _____

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 Noonan syndrome and related disorders. My healthcare provider should have provided me with information about the test(s) ordered and the condition(s) that may be identified. This information is also available on our website at http://pcpgm.partners.org/LMM
2. Genetic counseling is available to me and I have been provided with written information identifying genetic counselors, should I desire further information about this condition.
3. I have discussed with my genetic counselor that, 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 does diminish the likelihood that this gene is involved.
4. I have discussed with my genetic counselor that 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 have been informed and agree that my ordering provider will receive the results of my genetic tests and that the ordering provider will disclose the results to me.
10. I understand that my test results as well as any updates to those results may become part of my permanent medical record electronically or otherwise or be made available, electronically or otherwise, to the ordering healthcare institution and its healthcare team.

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)

_____
(If applicable) Name of patient's legal representative (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.

NS/ LS/ CFC/ Costello

Name: _____ **DOB:** ____ / ____ / _____ **(MM/DD/YYYY)**

GENE TEST TO BE PERFORMED:

NOONAN SPECTRUM DISORDERS (NOONAN, LEOPARD, CARDIO-FACIO-CUTANEOUS, and COSTELLO SYNDROMES)

☐ **Noonan Spectrum Gene Chip** (*PTPN11, SOS1, RAF1, KRAS, NRAS, SHOC2, BRAF, MEK1, MEK2, HRAS*)

Contact the laboratory for individual gene sequencing tests

FAMILIAL KNOWN MUTATION TEST

☐ **Familial Mutation Test** (Indicate gene, mutation, and information on proband (1st person tested) below)

Gene_____ Mutation_____ LMM Accession #: PM-_____

Proband Name_____ Relationship To Proband _____

PURPOSE OF STUDY

Clinical status: ☐ Symptomatic ☐ Asymptomatic

Purpose of study: ☐ Diagnostic ☐ Carrier Screen ☐ Presymptomatic ☐ Prenatal

☐ Other _____

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.

Clinical diagnosis: ☐ Noonan ☐ LEOPARD **ICD-9 Codes:** ☐ 759.89 (Noonan/LEOPARD)

(check all known/suspected clinical diagnoses) ☐ CFC ☐ Costello ☐ 759.8 (Other specified abnormalities)

Age at diagnosis: _____ ☐ Other _____

Ultrasound Finding: ☐ Cystic hygroma ☐ Increased NT - Size:_____ ☐ None

☐ Heart defect - Type: _____ ☐ Other _____

Congenital heart defect: ☐ Pulmonic valve stenosis ☐ Hypertrophic cardiomyopathy ☐ None

☐ Septal defect ☐ Other _____

Facial dysmorphism: ☐ Epicanthal folds ☐ Ptosis of the eyelids ☐ Low nasal bridge

☐ Hypertelorism ☐ Downward eye slant ☐ Low set ears and posteriorly rotated

☐ Papillomatas ☐ Coarseness ☐ None

Short stature: ☐ Yes - Height(%): _____ Parental Heights:_____ ☐ No

Cognitive development: ☐ Learning disabilities ☐ Developmental delay ☐ Mental retardation ☐ Normal

Skeletal: ☐ Pectus excavatum ☐ Pectus carinatum ☐ Scoliosis ☐ Normal

Genitourinary: ☐ Cryptorchidism (undescended testes) ☐ Normal

☐ Kidney malformation If yes, please describe: _____

Bleeding diathesis: ☐ Yes ☐ No If yes, please describe: _____

Hair/Skin findings: ☐ Yes ☐ No If yes, please describe: _____

Malignancy: ☐ Yes ☐ No If yes, please describe: _____

Other: _____

Previous Genetic Testing: ☐ No ☐ Yes Gene(s) _____

If variants detected, please elaborate: _____

Family history : ☐ Yes ☐ No (Sketch below or attach pedigree if appropriate)

Comments/Special Instructions:

Pedigree:

Standard Symbols

❍ = Female ☐ = Male

◇ = Gender unknown ⊙ = Carrier

■ ● ◆ = Affected individual

Ethnicity Paternal side: _____

Maternal side: _____

Consanguinity? ☐ Yes ☐ No