Mass General Brigham

Personalized Medicine
Laboratory for Molecular Medicine
Biobank Genomics Core
65 Landsdowne Street • Cambridge, MA 02139
Phone: (617) 768-8500 • Fax: (617) 768-8513 • Email: LMM@mgb.org
The LMM is a satellite facility of Massachusetts General Hospital. • CLIA # 22D1005307

Cardiovascular Polygenic Risk Requisition Form

SPECIMEN INFORMATION

Specimen:

Blood: ❑ Capillary ❑ Venous
❑ Saliva

Date Collected: (mm/dd/yyyy) _____ / _____ / _____

PATIENT INFORMATION

First name: _____ MI: _____

Last name: _____

Date of Birth: (mm/dd/yyyy) _____ / _____ / _____

Sex at Birth: ❑ Male ❑ Female ❑ Intersex

Gender: ❑ Male ❑ Female ❑ Prefer not to answer

Is patient pregnant? ❑ No ❑ Yes EDD: _____

❑ Ship kit to patient *(please complete address)*
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*

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

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 **Mass General Brigham 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.**

Patient Pay Billing Address: _____

_____

City: _____ State: _____

Zip Code: _____ Country: _____

Phone: _____

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 (*availabe on our website*). 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 (*https://www.massgeneralbrigham.org/en/research-and-innovation/centers-and-programs/personalized-medicine/molecular-medicine/working-with-lmm#accordion-acd7148c65-item-dc5691ec3f)*

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 prvacy/confidentiality by removing your name and other direct identifiers, such as SSN or medical record number, from data shared with other laboratories.

New York residents only: By initialing this section, I confirm that I am a New York state resident, and I give permission for LMM to retain any remaining sample longer than 60 days after the completion of testing, and to be used as a de-identified sample for test development and improvement, internal validation, quality assurance, and training purposes. Otherwise, New York state law requires LMM to destroy my sample after 60 days, and it cannot be used for test development. Please initial here if you wish to give permission to maintain your isolated DNA: _____

RESEARCH POLICIES & OPPORTUNITIES

Blood or other samples sent to the LMM may be used by Mass General Brigham (MGB), by medical organizations connected to MGB, or by educational or business organizations approved by MGB, for IRB approved research, education and other activities that support MGB'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.

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

New York State residents excluded, require lab to obtain full informed consent

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 written informed consent, as required by Massachusetts state law, and have abided by other consent requirements from 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 (*https://www.massgeneralbrigham.org/en/research-and-innovation/centers-and-programs/personalized-medicine/molecular-medicine/working-with-lmm#accordion-acd7148c65-item-dc5691ec3f)* for your convenience and DOES NOT need to be returned to the LMM.

Cardiovascular Polygenic Risk Requisition Form

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

TEST TO BE PERFORMED

Please check box(es) to order.

- ❑ MGB Polygenic Risk - Cardiovascular v1 (8 Conditions) – Atrial fibrillation, Coronary artery disease, Diabetes mellitus type 2, Elevated lipoprotein(a), Hypercholesterolemia, Hypertension, Thoracic aortic aneurysm, Venous thromboembolism
- ❑ MGB Polygenic Risk - Atherosclerosis v1 (5 Conditions) - Coronary artery disease, Diabetes mellitus type 2, Elevated lipoprotein(a), Hypercholesterolemia, Hypertension
- ❑ MGB Polygenic Risk - Thromboembolism v1 (4 Conditions) - Atrial fibrillation, Diabetes mellitus type 2, Hypertension, Venous thromboembolism
- ❑ MGB Polygenic Risk - Aneurysm v1 (2 Conditions) - Hypertension, Thoracic aortic aneurysm

CLINICAL INFORMATION

Clinical status: ❑ Affected ❑ Unknown ❑ Unaffected

ICD-10 Code(s): _____

Clinical Diagnosis: ❑ Coronary Artery Disease ❑ Atrial Fibrillation ❑ High Blood Pressure ❑ High LDL cholesterol
❑ High Lipoprotein(a) ❑ Type 2 Diabetes ❑ High Blood Pressure ❑ Thoracic Aortic Aneurysm
❑ Other_____

Bone Marrow Transplant: ❑ No ❑ Yes If Yes, Date of Transplant: _____

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.

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