MNG LABORATORIES
A LabCorp Company

# Known Familial Variant Test Request Form

5424 Glenridge Drive NE | Atlanta, GA 30342 USA | phone: 844.664.8378 | fax: 678.225.0212 | mnglabs.com

Patient Name _____ DOB _____

## ☐ *MNG Variant Investigation Program (MNG VIP®)*

- Qualifying Variants Only, Indicated on Proband Report
- No Charge Familial Testing

- **Effective for proband samples received after Oct. 15, 2018**
- Up to two (2) immediate familial samples are accepted (parents or siblings)
- Updated report for proband only, indicating any classification change or carrier status
- **Testing will not begin until all familial samples have been received**
- TAT 2-4 weeks, allow up to one week for processing and qualification

| Proband Information (REQUIRED for MNG VIP® and MNG samples) | |
|---|---|
| Proband Last Name | Proband First Name |
| **MNG ID / ACCESSION #** | Date of Birth [MM/DD/YYYY] |
| Diagnosis/ICD-10 | Gender ☐ Male ☐ Female |

**Please complete page 2 with family member/specimen details, variant details, and ordering physician information**

## ☐ *Familial Variant Testing*

- Non-qualifying Variants
- Additional Family Members
- External Lab Samples

- Applies to SNVs, CNVs, and mtDNA variants identified through MNG Labs
- Applies to SNVs and mtDNA variants identified through external laboratories
- All individuals tested will receive a report
- Please include billing information below
- TAT 2-4 weeks

| Proband Information (REQUIRED for MNG VIP® and MNG samples) | |
|---|---|
| Proband Last Name | Proband First Name |
| **MNG ID / ACCESSION #** | Date of Birth [MM/DD/YYYY] |
| Diagnosis/ICD-10 | Gender ☐ Male ☐ Female |

| Billing Information *(REQUIRED)* | | |
|---|---|---|
| Self-Pay? ☐ Yes | If yes, **MUST** include payer contact name & details below. Payment must be received in full prior to testing. | |
| Facility | | Contact Name |
| Billing Address | | |
| City, State, Zip Code | | |
| Phone | Fax | Email |

**Please complete page 2 with family member/specimen details, variant details, and ordering physician information**

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Patient Name _____ DOB _____

## Family Member 1 Information

| | | |
|---|---|---|
| Last Name | First Name | ☐ Male ☐ Female<br>**Specimen Type**<br>☐ Whole Blood ☐ Buccal Swab<br>☐ DNA: _____<br>☐ Tissue: _____ |
| Relationship to Proband | Date of Birth [MM/DD/YYYY] | |
| Affected? *Include Clinical Info*<br>☐ Yes ☐ No ☐ Unsure | Collection Date [MM/DD/YYYY] | |

## Family Member 2 Information

| | | |
|---|---|---|
| Last Name | First Name | ☐ Male ☐ Female<br>**Specimen Type**<br>☐ Whole Blood ☐ Buccal Swab<br>☐ DNA: _____<br>☐ Tissue: _____ |
| Relationship to Proband | Date of Birth [MM/DD/YYYY] | |
| Affected? *Include Clinical Info*<br>☐ Yes ☐ No ☐ Unsure | Collection Date [MM/DD/YYYY] | |

## Variant Information

| | |
|---|---|
| Gene Name | Variant Details |
| Gene Name | Variant Details |
| Gene Name | Variant Details |
| Gene Name | Variant Details |
| Gene Name | Variant Details |

## Referring Physician Information

| | |
|---|---|
| Physician Name | NPI # or equivalent *(Required)* |
| Facility / Organization | Signature |
| Facility Address City, State, Zip Code ☐ Same as billing | |
| Report Delivery ☐ Fax ☐ Email | Phone |

## Results

| | |
|---|---|
| Authorized Recipient Name | Authorized Recipient Name |
| Facility Phone | Facility Phone |
| ☐ Fax | ☐ Fax |
| ☐ Email | ☐ Email |

## Please include or attach any pertinent or additional clinical information:

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# Clinical Information Form

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## Clinical (Check All That Apply)

**Eye**
- ☐ Retinitis Pigmentosa
- ☐ Optic Atrophy
- ☐ Other

**Hearing**
- ☐ Sensorineural ☐ Stickler ☐ Usher

**Neuronal Migration**
- ☐ Meckel ☐ Joubert ☐ Other

☐ Stroke

**Cognitive/Neurobehavioral**
☐ Intellectual Disability (ID) ☐ Syndromic ID ☐ Nonsyndromic ID ☐ Autism ☐ Dementia

**Movement Disorders**
☐ Ataxia ☐ Episodic Ataxia ☐ Dystonia ☐ Chorea/Athetosis ☐ Parkinson Disease ☐ L-Dopa Response

**Epilepsy** ☐ Myoclonic ☐ Other
- ☐ Absence ☐ Tonic Clonic
- ☐ Epileptic Encephalopathy

**Spasticity**
- ☐ Spastic Paraplegia ☐ Other
- ☐ Spastic Quadriplegia

**Connective Tissue & Bone**
- ☐ Ehlers Danlos ☐ Marfan ☐ Aneurysms
- ☐ Other

**Neuromuscular**
- ☐ Distal ☐ Proximal ☐ Muscle Atrophy ☐ Contractures
- ☐ Malignant Hyperthermia ☐ Arthrogryposis ☐ Rhabdomyolysis
- ☐ Periodic Paralysis ☐ Statin Use ☐ Myasthenia

**Nerve/Anterior Horn Cell**
- ☐ Neurofibromas ☐ Charcot-Marie-Tooth ☐ Sensory
- ☐ Autonomic ☐ Pain ☐ Motor ☐ Nerve Conduction
- ☐ Other

**Cardiomyopathy**
- ☐ Dilated ☐ Hypertrophic
- ☐ Noncompaction

**Arrhythmias**
- ☐ Ventricular Tachycardia ☐ Brugada
- ☐ Long or Short QT ☐ Conduction Defect

**Congenital Heart Defects**
- ☐ Heterotaxy
- ☐ Other

**Endocrine**
- ☐ Hypothyroidism ☐ Other
- ☐ Diabetes Mellitus

## Imaging (Check All That Apply)

**Brain MRI**
- ☐ Leigh Disease
- ☐ Basal Ganglia Calcification
- ☐ Stroke
- ☐ Cerebellar Atrophy
- ☐ Abnormal Myelin (describe)

**EEG (Describe Findings)**

**EMG/NVC (Describe Findings)**

## Laboratory

**Metabolic (Describe Findings)**

**CPK** Maximum _____
Minimum _____

**Genetic (Describe Findings)**
- ☐ Chromosomal Microarray
- ☐ Deletion/Insertion Testing
- ☐ Other (comment)

## Family History

**Ethnicity (please check)**

☐ Caucasian ☐ Sephardic Jewish ☐ African American (or Black) ☐ Asian
☐ Hispanic ☐ Ashkenazi Jewish ☐ Native American (or American Indian) ☐ Other: _____

| Affected Maternal Lineage | Affected Paternal Lineage | Siblings |
|---|---|---|
| Relationship to Proband | Relationship to Proband | Number (specify gender) |
| Symptoms | Symptoms | Healthy/Affected |

**Additional Comments**

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# Informed Consent for Genetic Testing

**In compliance with New York State Civil Law: Section 79-L**

5424 Glenridge Drive NE | Atlanta, GA 30342 USA | phone: 678.225.0222 | fax: 678.225.0212 | mnglabs.com

Patient Name _____ DOB _____

**Please provide a copy of completed consent with sample and requisition. Failure to do so may delay testing.**

***When signed and dated, this written consent is written authorization to participate in genetic testing.***

1. **Purpose of the Test:** My physician has explained the recommended testing: _____ (name of test or MNG test code), which is performed to help diagnose _____ _____(insert disease description). I am aware that all documentation regarding this testing, including the description of the purpose, methodology, and disorders is freely available at www.mnglabs.com/tests and has either been reviewed with me by my physician or I have read the documentation on my own. **Patient (or parent/guardian) initials:** _____

2. **Statement Regarding Test Result:** A positive test result is an indication that the individual has a genetic cause for the specific disease tested for. A negative result may/may not rule out a genetic disorder depending on clinical history and quality/type of specimen tested. The individual may wish to consider further independent testing, consult a personal physician or pursue genetic counseling.

3. **Level of Certainty:** Is test-specific and determined by the methods employed, patient's clinical history and sometimes by the nature of the patient's condition at time of sampling. There is always a small possibility of error or failure in sample analysis; this is true with complex testing in any laboratory. Inclusion of clinical data, such as medical history, family history, images as they relate to the disease or disorder, will decrease the level of uncertainty in an interpretation and are encouraged to be included when submitting samples for analysis. MNG Laboratories will keep personal information private in accordance with HIPAA laws.
   **I consent to the retention of these documents by MNG Laboratories in their database.**
   **Patient (or parent/guardian) Initials:** _____

4. **Disclosing Test Results:** The following categories of persons or organizations that test results may be released to include, but are not limited to: hospitals or laboratories involved in the patient's care, referring physician(s) and primary care providers, other physician groups (consultants, surgeons), insurance companies (as provided by the patient or referring physician for payment purposes), and other professionals involved in patient care that assist MNG Laboratories in carrying out treatment, payment, and operational activities. Results are kept confidential. Medical Neurogenetics complies with security and privacy statutes of the federal Health Information Portability and Accountability Act (HIPAA). If a patient chooses to specifically declare where results may be released (other than the referring institution and ordering physician), please provide these *in writing* to the Compliance Officer, MNG Laboratories (quickresponse@mnglabs.com).

5. **Consent to Retain Specimen:** The laboratory does not return any remaining sample to individuals or physicians unless requested. No clinical tests other than those authorized shall be performed on the sample. A request for additional testing must be made by my referring physician or other authorized healthcare professional and there will be an additional charge. If agreed by the patient, MNG Laboratories will retain the samples for longer periods for use in an anonymous fashion for research/development or for quality assurance processes.
   **I consent to have my specimens retained after completion of initial testing (this consent may be withdrawn at any time and the laboratory will destroy any remaining sample). Patient (or parent/guardian) Initials:** _____

6. **Testing for Genetic Conditions can be Complex:** If warranted, obtain professional genetic counseling prior to giving consent to fully understand what the risks and benefits are to having the testing completed. I hereby consent to participate in testing described above. I understand that a biologic specimen will be obtained from me and/or members of my family. I understand that this biologic specimen will be used for the purpose of attempting to determine if I, or members of my family, are affected or are carriers of a particular disease or are at increased risk to someday be affected with this genetic disease.

_____ _____
**Signature of Patient** Date

_____ _____
**Authorized Signature (Parent/Guardian)** Relationship

_____ _____
Name of Patient (*please print clearly*) Name of Ordering MD (*please print clearly*)

_____ _____
Referring Facility (*please print clearly*) **Signature of Ordering MD**

**Important: One signature from patient (or parent/guardian), authorized person, or physician is required to complete this form. New York requires signatures from patient (or parent/guardian) OR ordering physician to complete this form.**