MOLECULAR (DNA) BANKING REQUISITION

Center for Human Genetics, Inc.
Riverside Technology Center
840 Memorial Drive, Suite 101
Cambridge, MA 02139
Co-directors: Aubrey Milunsky, M.D., D.Sc., Jeff Milunsky, M.D.
Phone: 617-492-7083 **Fax: 617-492-7092**
Website: http://www.chginc.org

FOR **CHG** LAB USE ONLY:
Date received: ____________________
Pedigree #: ____________________
Family name: ____________________
Sample type: ____________________
Lab #: ____________________

Patient Name: ______________________________ ◻ **Male** ◻ **Female** ◻ **Unknown**
Last First MI

Hospital/Patient ID#: ____________________

Date of Birth: ____________________

Address: ______________________________
____
City State Zip Code

Partner/Parent of: ____________________

Phone: ____________________

Referring Provider: **NPI #**: ____________________

Physician signature: ____________________

Name: ____________________

Address: ____________________
____
City State Zip Code

Phone: ____________ Fax: ____________

Referring Laboratory (if different):

Name: ____________________

Address: ____________________
____
City State Zip Code

Phone: ____________ Fax: ____________

Genetic Counselor: ____________________

Phone: ____________ Fax: ____________

Email: ____________________

**** Billing information (Page 4) MUST accompany sample and requisition form. Consent form (Page 2) is REQUIRED for all samples ****

Ethnicity:
◻ Ashkenazi Jewish ◻ French Canadian ◻ Caucasian ◻ African American ◻ Asian ◻ Hispanic
◻ Sephardic Jewish ◻ Armenian ◻ Turkish ◻ Mediterranean ◻ Arabic ◻ Other: ________

Diagnosis/Additional Information :
____
____

DNA TEST REQUESTED: ◻ Banking (circle type) DNA or Lymphoblast

Date Sample Collected: ____________________

Specimen Recommendation for DNA Banking: 10-20cc of blood in EDTA anticoagulant (lavender top tube)

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Patient Name: ____ **Date of Birth:** ________________________
Last First MI

INFORMED CONSENT FOR DNA/LYMPHOBLAST BANKING

I/We ____ request and authorize the Molecular Genetics Laboratory at the Center for Human Genetics, Inc. to isolate DNA/establish a cell line from a blood/tissue specimen obtained from ____ (name of person whose sample is being banked), so that such DNA/cell line may be preserved for my/my family's future medical use. In the event that no DNA/cell line is obtained from this current specimen, I/we understand that an additional specimen will be requested.

I/We understand that no testing will be performed on this sample without written authorization from myself or my legal guardian. This sample will be released to another facility for testing only at the written request of myself or my legal guardian. The Center for Human Genetics, Inc. will not be held responsible for the results of diagnostic testing performed on this sample at other facilities.

I/We understand that the Center for Human Genetics, Inc. will retain this DNA/cell line in its repository for the useful life of the sample. While the Center for Human Genetics, Inc. does not intend to cease operation of the DNA/lymphoblast banking facility, should any change affecting the storage of samples occur, the Center for Human Genetics, Inc. will use all reasonable efforts to notify each donating family to determine the disposition of the sample. Although the Center for Human Genetics, Inc. will use all reasonable efforts to store the sample safely, I/we understand that the integrity of the stored sample could be compromised by equipment or power failure, flood or other catastrophe, possibly rendering the sample inadequate for requested testing in the future. In addition, the protocols that the Center for Human Genetics, Inc. will use to store the sample may not be sufficient for all types of genetic tests that may be developed in the future.

My signature below acknowledges my understanding of and agreement to all of the foregoing as well as my voluntary participation in DNA/lymphoblast banking.

Signature (patient): ____ Date: __________

OR

Signature (legal guardian/health care proxy): ____

Witnessed by: ____ Date: __________

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Patient Name: ____ **Date of Birth:** ________________________
Last First MI

ACCESS TO BANKED DNA

I/We ____ agree to provide access to my banked DNA at the Center for Human Genetics, Inc to (***see list below***) in the event of my death.

Name: ____________________ Email and/or phone #: ____________________

Name: ____________________ Email and/or phone #: ____________________

Name: ____________________ Email and/or phone #: ____________________

Name: ____________________ Email and/or phone #: ____________________

Name: ____________________ Email and/or phone #: ____________________

Signature (patient): ____ Date: ___________

OR

Signature (legal guardian/health care proxy): ____________________________________

Witnessed by: ____ Date: ___________

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Patient Name: ________________________________ **Date of Birth:** ____________________
Last First MI

BILLING

For DNA banking, there is a one time fee of $450. Please complete the form below for credit card payment. Certified checks are also accepted.

Credit card type: (Please circle) MasterCard VISA American Express

Card holder name:

Credit Card #:

Expiration Date:

Security Code:

Amount to Authorize: $450.00

Signature:

Contact Name:

Contact Email:

Contact Telephone # ( )

Certified checks should be made payable to:

Center for Human Genetics, Inc
Federal Tax Id #04-3154223

If you would prefer to be contacted upon receipt of sample for payment, please indicate who to contact for this information.

Name: ___________________________________ **Telephone Number:** ______________________

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DNA Banking Sample Requirements and Shipping Information

1. Draw lavender top (EDTA anticoagulant) tubes of blood (10-20 cc) from the patient. Label the tubes with the patient's full name and date of birth. Maintain the sample at room temperature. Sample stability is approximately 5-7 days.

2. Pack the tubes in a sealed plastic bag and place in a container with sufficient material to absorb the entire volume of blood if the tubes should break to prevent the possible spread of blood-borne pathogens. Send the sealed container overnight through ***FedEx*** or ***UPS***. DO NOT USE EXPRESS MAIL THROUGH THE POST OFFICE. Send samples to arrive Monday through Friday. Do NOT mail on Friday, as the laboratory is closed weekends. Be alert for Monday public holidays and avoid delivery on long-weekends. If a sample is collected on Friday, do not mark for Saturday delivery. Federal Express will normally deliver the sample on the following Monday.

3. Include the attached DNA Banking Requisition along with the sample. Please fill in these forms as completely as possible.

4. Address all samples to:

ATTN: Aubrey Milunsky, M.D., D.Sc.
Center for Human Genetics, Inc.
Riverside Technology Center
840 Memorial Drive, Suite 101
Cambridge, MA 02139

If you have any questions, please call the DNA coordinator at 617-492-7083.