HARVARD MEDICAL SCHOOL | MASSACHUSETTS EYE AND EAR
OCULAR GENOMICS INSTITUTE
GENETIC DIAGNOSTIC LABORATORY
243 Charles Street, Boston, MA 02114
Email: OGI_Diagnostics@meei.harvard.edu

SPECIMEN INFORMATION

Specimen: ☐Blood ☐DNA ☐Other: _____

Date collected (mm/dd/yyyy):____ / _____ /_____

PATIENT INFORMATION

First Name: _____ Last Name: _____
Date of birth: (mm/dd/yyyy) _____ Gender: ☐Male ☐ Female ☐Unknown

Institution: _____
Medical Record Number: _____

Address: _____
City: _____
State: _____ Zip code: _____
Phone number: _____

REFERRING PROVIDER INFORMATION

Referring Provider
Name: (First, Last): _____
Phone: _____ Fax: _____
Institution: _____
Address: _____
_____
City: _____ State: _____
Zip code: _____

Genetic Counselor/Additional Contact
Name: (First, Last): _____
Phone: _____ Fax: _____
Email: _____
Institution: ☐ Same as Referring Provider ☐ Provided Below
_____
_____

DIAGNOSTIC TESTS (check the box(es) to order)

☐ **Genetic Eye Disease Panel for Retinal genes (GEDi-R):** $2850.00

☐ **Genetic Eye Disease Panel for Optic Nerve genes and Early onset Glaucoma (GEDi-O):** $1650.00

☐ **Genetic Eye Disease Panel for Strabismus Genes (GEDi-S):** $1250.00

☐ **Relative's sample for:** GEDi-R or GEDi-O (please circle)
Proband's Name: _____
Relationship to Proband: _____

☐ **Research Confirmation / Familial Variants:** $ 500.00
Gene name: _____
Variant(s): _____
_____
Proband's Name: _____
Relationship to Patient: _____

For Office Use:
Accession # _____

NAME (First and Last)_____ DOB (mm/dd/yyyy):__ __/__ __/_____

CLINICAL INFORMATION

Clinical status: ☐ Affected ☐ Unaffected ☐ Glaucoma suspect ☐ Unknown
Purpose for testing: ☐ Diagnostic ☐ Carrier testing ☐ Other: _____

Clinical Diagnosis: _____
Age of onset: _____

Please provide relevant clinical information:
_____
_____
_____

Siblings with or other family history of similar vision problems? ☐ Yes ☐ No

Sketch a pedigree below if appropriate:

Maternal Ethnicity:_____
Paternal Ethnicity: _____

◯ = Female ☐ = Male ◇ = Gender Unspecified ● ■ ◆ = Affected individual

INFORMED CONSENT

I understand that:

1) The purpose of this test is to determine if I (or my child) has a mutation in a gene that has been found to be associated with eye disease.
2) Genetic counseling is available to me should I desire more information.
3) A negative genetic test does not rule out a diagnosis of, a predisposition towards, or the ability to pass on eye disease, but it does diminish the likelihood that the gene(s) that will be tested for are involved in the disease.
4) This genetic test is specific for one type of eye disease and does not test for any other condition. Therefore, a negative test does not guarantee my health or 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 involves 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 laboratory will make every attempt to report results as soon as possible, but cannot accept responsibility for delays.
8) Your results will be given to your health care provider who will discuss them with you.

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.

_____ _____ _____
Patient Signature Print Name Date

OR

_____ _____ _____
Parent/Guardian Signature Print Name Date

_____
Relationship to Person

Research Opportunities

The Ocular Genomics Institute conducts research about inherited eye disease. If you would like to be contacted to let you know about research studies in which you/your child may be able to participate, please check off the following:

☐ Yes, please contact me (____ patient initials)

_____ ☐ 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 Ocular Genomics Diagnostic Laboratory listed above. I have obtained informed consent, as required by my own state, the state of Massachusetts 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 his\her test results.

_____
Signature Date

PAYMENT INFORMATION- *This section MUST be completed for testing to begin*

☐ Patient Pay ☐ Check ☐ Credit card

Credit card type: ☐ Mastercard ☐ Visa ☐ American Express
Name (as it appears on card): _____
Credit Card Number: _____
Expiration Date: _____ 3 digit Security Code: _____

Patient Pay billing address: _____
City: _____ State: _____ Zip code: _____ Country: _____
Home phone: _____ Cell/work: _____

Please bill my credit card in the amount of $_____ for diagnostic laboratory tests performed by Ocular Genomics Diagnostic Laboratory at Massachusetts Eye and Ear Infirmary

I understand, acknowledge and agree that I am responsible for payment of the charges for my genetic testing for inherited eye disease at Massachusetts Eye and Ear Infirmary. I understand that the decision whether to proceed in light of any non-coverage and non-payment by the plan is mine alone, and that I understand the consequences of not proceeding with the service. I further agree that the foregoing agreement supersedes any prior agreement entered into by me or on my behalf and that a copy of this agreement has been given to me.

_____
Signature of patient or legally responsible party (REQUIRED) Date

☐ **Institutional Billing**
Bill to Name/Department: _____
Address: _____
City: _____ State: _____ Zip code: _____
Contact person: _____