



Proband Information (REQUIRED for MNG Answers®)

Proband Last Name		Proband First Name	
MNG ID / ACCESSION #		Date of Birth [MM/DD/YYYY]	
Diagnosis/ICD-10		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Additional Sample Information: Collection Date [MM/DD/YYYY]	Specimen Type <input type="checkbox"/> Whole Blood <input type="checkbox"/> Fibroblasts <input type="checkbox"/> Buccal Swab <input type="checkbox"/> DNA Tissue: _____		

NGS Panel Reflex to MNG Exome

- Allow up to one week for processing and qualification
- **Testing will not begin until all samples to be analyzed are received**
- Consent forms **must** be included for whole exome sequencing

- MNG Exome - Trio Sequencing
 MNG Exome - Duo Sequencing
 MNG Exome - Proband Only Sequencing

MNG Exome Reflex to MNGenome®

- Allow up to one week for processing and qualification
- **Testing will not begin until all samples to be analyzed are received**
- RNA Sequencing can be ordered separately

- MNGenome® - Trio Sequencing
 MNGenome® - Proband Only Sequencing

Family Member 1 Information

Last Name	First Name	<input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Proband	Date of Birth [MM/DD/YYYY]	Specimen Type <input type="checkbox"/> Whole Blood <input type="checkbox"/> Buccal Swab <input type="checkbox"/> DNA: _____ <input type="checkbox"/> Tissue: _____
Affected? <i>Include Clinical Info</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Collection Date [MM/DD/YYYY]	

Family Member 2 Information

Last Name	First Name	<input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Proband	Date of Birth [MM/DD/YYYY]	Specimen Type <input type="checkbox"/> Whole Blood <input type="checkbox"/> Buccal Swab <input type="checkbox"/> DNA: _____ <input type="checkbox"/> Tissue: _____
Affected? <i>Include Clinical Info</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Collection Date [MM/DD/YYYY]	

Negative MNG Exome Reflex to MNG Transcriptome

IMPORTANT: Please contact MNG Laboratories prior to ordering RNA sequencing to avoid delay in sample processing

- Allow up to one week for processing and qualification

Patient Information (REQUIRED for MNG Answers®)

Last Name	First Name
MNG ID / ACCESSION #	Date of Birth [MM/DD/YYYY]
Diagnosis/ICD-10	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Collection Date [MM/DD/YYYY]	Specimen Type <input type="checkbox"/> Blood <input type="checkbox"/> Fibroblasts <input type="checkbox"/> Skin Biopsy <input type="checkbox"/> Muscle Biopsy <input type="checkbox"/> Brain/Nerve Biopsy

- MNG Transcriptome - Full RNA sequencing
 Gene Specific RNA Sequencing - Up to 5 Genes _____

Please complete page 2 with billing information and ordering physician details



Referring Physician Information

Physician Name	NPI # or equivalent <i>(Required)</i>
Facility / Organization	Signature
Report Delivery <input type="checkbox"/> Fax	<input type="checkbox"/> Email Phone

Billing Information *(REQUIRED)*

Self-Pay? <input type="checkbox"/> 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

Results

Authorized Recipient Name	Authorized Recipient Name
Facility	Facility
Phone	Phone
<input type="checkbox"/> Fax	<input type="checkbox"/> Fax
<input type="checkbox"/> Email	<input type="checkbox"/> Email

Please include or attach any pertinent or additional clinical information:



Clinical Information Form

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

Patient Name _____ DOB _____

Clinical (Check All That Apply)

Eye <input type="checkbox"/> Retinitis Pigmentosa <input type="checkbox"/> Optic Atrophy <input type="checkbox"/> Other	Hearing <input type="checkbox"/> Sensorineural <input type="checkbox"/> Stickler <input type="checkbox"/> Usher	Neuronal Migration <input type="checkbox"/> Meckel <input type="checkbox"/> Joubert <input type="checkbox"/> Other	<input type="checkbox"/> Stroke
Cognitive/Neurobehavioral <input type="checkbox"/> Intellectual Disability (ID) <input type="checkbox"/> Syndromic ID <input type="checkbox"/> Nonsyndromic ID <input type="checkbox"/> Autism <input type="checkbox"/> Dementia			
Movement Disorders <input type="checkbox"/> Ataxia <input type="checkbox"/> Episodic Ataxia <input type="checkbox"/> Dystonia <input type="checkbox"/> Chorea/Athetosis <input type="checkbox"/> Parkinson Disease <input type="checkbox"/> L-Dopa Response			
Epilepsy <input type="checkbox"/> Myoclonic <input type="checkbox"/> Other <input type="checkbox"/> Absence <input type="checkbox"/> Tonic Clonic <input type="checkbox"/> Epileptic Encephalopathy	Spasticity <input type="checkbox"/> Spastic Paraplegia <input type="checkbox"/> Other <input type="checkbox"/> Spastic Quadriplegia	Connective Tissue & Bone <input type="checkbox"/> Ehlers Danlos <input type="checkbox"/> Marfan <input type="checkbox"/> Aneurysms <input type="checkbox"/> Other	
Neuromuscular <input type="checkbox"/> Distal <input type="checkbox"/> Proximal <input type="checkbox"/> Muscle Atrophy <input type="checkbox"/> Contractures <input type="checkbox"/> Malignant Hyperthermia <input type="checkbox"/> Arthrogryposis <input type="checkbox"/> Rhabdomyolysis <input type="checkbox"/> Periodic Paralysis <input type="checkbox"/> Statin Use <input type="checkbox"/> Myasthenia		Nerve/Anterior Horn Cell <input type="checkbox"/> Neurofibromas <input type="checkbox"/> Charcot-Marie-Tooth <input type="checkbox"/> Sensory <input type="checkbox"/> Autonomic <input type="checkbox"/> Pain <input type="checkbox"/> Motor <input type="checkbox"/> Nerve Conduction <input type="checkbox"/> Other	
Cardiomyopathy <input type="checkbox"/> Dilated <input type="checkbox"/> Hypertrophic <input type="checkbox"/> Noncompaction	Arrhythmias <input type="checkbox"/> Ventricular Tachycardia <input type="checkbox"/> Brugada <input type="checkbox"/> Long or Short QT <input type="checkbox"/> Conduction Defect	Congenital Heart Defects <input type="checkbox"/> Heterotaxy <input type="checkbox"/> Other	Endocrine <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Other <input type="checkbox"/> Diabetes Mellitus

Imaging (Check All That Apply)

Brain MRI <input type="checkbox"/> Leigh Disease <input type="checkbox"/> Basal Ganglia Calcification <input type="checkbox"/> Stroke <input type="checkbox"/> Cerebellar Atrophy <input type="checkbox"/> Abnormal Myelin (describe)	EEG (Describe Findings) _____	EMG/NVC (Describe Findings) _____
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Laboratory

Metabolic (Describe Findings) _____	Genetic (Describe Findings) _____
CPK Maximum _____ Minimum _____	<input type="checkbox"/> Chromosomal Microarray <input type="checkbox"/> Deletion/Insertion Testing <input type="checkbox"/> Other (comment)

Family History

Ethnicity (please check) <input type="checkbox"/> Caucasian <input type="checkbox"/> Sephardic Jewish <input type="checkbox"/> African American (or Black) <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Native American (or American Indian) <input type="checkbox"/> Other: _____		
Affected Maternal Lineage Relationship to Proband _____ Symptoms _____	Affected Paternal Lineage Relationship to Proband _____ Symptoms _____	Siblings Number (specify gender) _____ Healthy/Affected _____

Additional Comments



Informed Consent Whole Exome & Whole Genome Sequencing

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

Patient Name _____

DOB _____

Notice to Health Care Practitioner:

This document is a consent form for clinical whole exome or whole genome sequencing. Currently, the laboratory will only accept whole exome and whole genome test requests after the patient/parent or legal guardian/next of kin has received genetic counseling from a Healthcare Provider with experience in counseling patients for such a test. Please be aware of any applicable state laws in regards to counseling needs related to the current condition, the possibilities of detecting unsuspected conditions as well as other issues related to health insurance, and possible effects on life insurance. Please explain this consent to the patient, or authorized representative/guardian, and obtain an informed consent. Please explain the list of potential incidental findings that may be reported to the patient.

Informed Consent for Patients and/or Legal Guardians:

What is whole exome sequencing (WES) and whole genome sequencing (WGS)?

Whole exome sequencing (WES) and whole genome sequencing (WGS) are genetic tests. They are performed on DNA extracted from 3 ml of blood or other acceptable tissue type. Their purpose is to identify a heritable cause of a disorder. WES examines the "exome" or coding regions of DNA, the most important information containing segment of the genome, and will often identify the cause of disease. WGS examines all of the DNA in the human genetic code including coding and non-coding regions.

The sensitivity of both tests is improved if blood is submitted from biological parents or siblings of the patient. The goal of both tests is to identify the genetic cause of the disease for which the patient is presenting. For this reason, it is crucial that a detailed description of the clinical symptoms of the patient and other affected family members is provided. Results will only be reported on the patient. Because WES and WGS results have potential consequences for the patient's family, we recommend that the consenting and ordering process be performed with the assistance of a genetic counselor and/or the ordering physician.

What kind of results are reported?

1. Positive: Variant(s) have been identified that are known to cause the disease symptoms based on the available scientific evidence at the time of testing.
2. Indeterminate: Variant(s) have been identified that are likely to cause the disease symptoms based on the available scientific evidence at the time of testing, but there is a lack of definitive scientific evidence available to prove it.
3. Negative: No variant has been identified that is known or likely to cause the disease symptoms based on the available scientific evidence at the time of testing.

What implications do positive and negative results have?

When WES/WGS detects known disease causing variants, the test result is highly accurate. A positive result will help your clinician to better predict the course of the condition and provide you with treatment options, if they exist. The results will also help determine the risk of recurrence of the condition in other children. An indeterminate result will point to a probable cause of a condition, but you may wish to consult a genetic counselor or your physician and undergo further independent testing to confirm or rule out the proposed role. A negative result does not indicate the absence of a genetic cause and will not change the clinical diagnosis.

Are there limitations to WES and WGS testing?

WES and WGS are screening tests. There is a possibility a genetic variant caused a condition that is not identified by the WES/WGS tests either because of the technical limitations of the assays, or because of incomplete understanding of the significance of variants detected. Although WES/WGS testing is highly accurate, the interpretation of the report is based on current medical knowledge, which is not complete.

1. WES may not be able to detect genetic disorders that are caused by expansion of repetitive regions of the genome. One example is Fragile X Syndrome. If one of these types of conditions is suspected, your physician should order the appropriate test.
2. Not all regions in the human genome can be sequenced due to limitations in technology, so some variants in such regions might go undetected with WGS methodologies.

What are incidental findings?

During testing, disease causing variants can be identified that are not related to the patient's condition for which the testing was done. These are referred to as "Incidental Findings" and indicate the presence of previously undiagnosed, potentially serious conditions that can be prevented or treated if diagnosed. A list of such conditions based on the recommendation of the American College of Medical Genetics (ACMG) is provided on our website. Please state whether you want to be informed about incidental findings in relation to the conditions listed.

_____ (initials) I would like to learn of incidental findings to the conditions listed (Proband Only)

_____ (initials) I would like to learn of incidental findings to the conditions listed (Proband + Parents)

_____ (initials) I would NOT like to learn of incidental findings to the conditions listed.

Are there results that will not be reported?

1. Samples from the patient's relatives may be used to help diagnose the patient's condition, but results for these relatives will not be reported independently. They will only be referred to in the report for the patient if they are directly relevant to the patient's condition. However, the patient's genetic results may have implications for their relatives, and it is important that these implications are discussed with a genetic counselor.
2. Variations in genes that affect susceptibility to a condition, but do not cause the person to develop the condition, will not be reported.
3. Carrier status for recessive disorders will not be reported. Most people carry variants that are not disease causing but could become disease causing if that person had children with someone who was healthy, but had the same variant. This is referred to as being a "carrier" for a disease. If you are concerned about carrier status for conditions that might run in your family, you should get tested separately for carrier status. You should discuss these implications with your genetic counselor.

NEXT >>



MNG LABORATORIES

A LabCorp Company

Informed Consent Whole Exome & Whole Genome Sequencing

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

Patient Name _____

DOB _____

Who will have access to the results?

Test results are maintained electronically by the laboratory. The results are provided to the ordering physician and/or healthcare facility that ordered the test. Results may also be made available to individuals/organizations with a legal right of access under applicable Federal and/or State law, or as authorized by the patient or the patient's representative. Patient privacy is of utmost concern to us, and as a CAP certified facility we are prepared to safeguard Protected Health Information.

How long are WES and WGS results kept in the testing lab?

The laboratory may keep the identified WES/WGS raw data in the lab indefinitely. This helps us improve our diagnostic capabilities and will help others with similar conditions. To advance the understanding of genetic disorders, your results might be analyzed and published in scientific articles in a de-identified manner consistent with HIPAA guidelines.

_____ (initials) We agree that our WES/WGS data may be stored indefinitely

_____ (initials) We agree that our WES/WGS data may be used for scientific publication in a de-identified manner

What will happen to my DNA sample?

No additional tests will be performed on these samples, without specific, signed authorization by the individual(s). After 60 days, unless consent is given below, the sample will be destroyed.

_____ (initials) (Proband) Please keep my DNA used for WGS/WES for future testing should I desire such testing or if I want to participate in research in the future. I understand no additional genetic tests will be performed without my specific consent/instructions, but my DNA may be used for quality control purposes. I understand that there is no guarantee of availability of my DNA after 60 days.

_____ (initials) (Parents(s)) Please keep our DNA used for WGS/WES for future testing should we desire such testing or if we want to participate in research in the future. We understand no additional genetic tests will be performed without our specific consent/instructions, but our DNA may be used for quality control purposes. We understand that there is no guarantee of availability of our DNA after 60 days.

What are the risks of testing?

1. Non-paternity (when the reported father of the child is not the biological father) or half sibling-ships (when siblings do not share the same father AND mother) would be detected. We do not report these findings unless they have direct clinical significance.
2. Genetic non-discrimination law prevents insurance companies from using your genetic information to deny health insurance coverage, but the law does not cover life insurance, disability insurance or long-term care insurance. The detection of an incidental condition may affect your future ability to buy these forms of insurance or get the best insurance rates. Please be aware of any applicable State laws and applicable terms of any active insurance policies in regards to consent and the release of these results to insurance companies.
3. WES/WGS may identify serious and/or untreatable genetic conditions. It can result in unexpected psychological trauma, both for you and your family. The detection of such a condition or conditions could also affect the health or healthcare needs of your siblings, children, or other close relatives.
4. Although WES/WGS is highly accurate, the interpretation of the report is based on current medical knowledge, which is not complete. We do not report out changes in interpretation of variants automatically, but we do have mechanisms to issue an updated report if requested by the patient's physician.

Consent for WES and WGS Testing

All of the above has been explained to me, to my satisfaction, and my signature below attests to the same. I understand that this is a voluntary test, and I have had the opportunity to ask questions about alternative testing.

Whole Exome or Whole Genome Sequencing Participant (Parent/Guardian of child being tested):

Print Name: _____

Date: _____

Signature: _____

Date of Birth: _____

I have provided genetic counseling and have explained the risks, benefits, and limitations of WES testing to the patient/parent/guardian.

Health Care Provider Obtaining Consent:

Print Name: _____

Date: _____

Signature: _____

NPI#: _____

Consent of family members submitting a sample for evaluation of patient's results

I understand that I am submitting my sample to help evaluate the results obtained on the person being tested, and that results obtained from my sample will be used solely for this purpose. I will NOT be informed of any test results on my sample. If I request any test results, I will have to be tested separately.

Name of Family Member: _____

Relationship to Proband: _____

Signature: _____

Date: _____

Name of Family Member: _____

Relationship to Proband: _____

Signature: _____

Date: _____

Name of Family Member: _____

Relationship to Proband: _____

Signature: _____

Date: _____