



Cedars-Sinai Medical Center  
 Department of Pathology and Laboratory Medicine  
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PowerPath Case #	CSMC MRN Only	Client Patient ID#	<b>PERSIAN JEWISH GENETIC TESTING</b>	
	Patient Name (Last, First, M)		Social Security #	
M.D./Client Name Account Information	Address		DOB	Sex
	City	State	Zip	Phone
	Responsible Party (If other than patient)		Relationship to Patient <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian	
	Bill To: <input checked="" type="checkbox"/> M.D./Client only			
	Date Collected	Time Collected	Specimen Type/Source	
<input type="checkbox"/> Call to:		<input type="checkbox"/> Fax to:		

### PERSIAN JEWISH GENETIC PANEL

- Pseudocholinesterase deficiency
- Polyglandular deficiency
- Congenital hypoadosteronism
- Hereditary inclusion body myopathy (HIBM).

Please select one:

- With Pathologist Consult (Recommended) (PJSBB-PIR)  
 Result only (PJSBB-NOPIR)

Specimen Requirement: Submit one Oragene® saliva tube or one 4 mL lavender top tube (EDTA) whole blood

Indicate reason for test:

- Screen  
 Diagnosis; indication: \_\_\_\_\_

Participant Information: Are both your parents of Persian Jewish ancestry?  Yes  No

Please indicate which of the following *are* of Persian Jewish ancestry and include their *birth city* on the line below:

- Maternal Grandmother       Maternal Grandfather       Paternal Grandmother       Paternal Grandfather
- \_\_\_\_\_

Additional Request:

#### FOR MEDICAL GENETICS USE ONLY

- MC       Visa       American Express       I prefer to pay cash or by check

Credit Card Number:	Expiration Date:	3 Digit Security Code (on back of card):
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Please bill my credit card in the amount of \$ \_\_\_\_\_ for services provided by Cedars-Sinai Medical Center

Signature (Required): \_\_\_\_\_

#### Patient Consent

Your signature below indicates that you understand to your satisfaction the information regarding genetic testing described on the back of this requisition and agree to have the test(s) done. In no way does this waive your legal rights or release anyone from their legal and professional responsibilities. If you have further questions concerning matters related to this consent, please discuss them with your medical geneticist, genetic counselor, or referring physician. If you wish to speak to our genetic counselor, please contact Catherine Quindipan at (310)423-9547.

\_\_\_\_\_  
 Signature of patient or legal guardian

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of health care provider

\_\_\_\_\_  
 Date

Patient's Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

Patient's ID# \_\_\_\_\_ Referring Physician/  
Genetic Counselor: \_\_\_\_\_

I have had an opportunity to read a patient information brochure provided, and/or my physician has explained the risks, benefits and limitations for the test ordered.

It is recommended that I/my child have this test because:

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(Reason for test)

I understand the following and freely give my consent to this genetic test. I understand that:

- The test may provide an indication of risk, or diagnosis, or possible diagnosis, for me or my child.
  - The ability of genetic testing to provide risk information or a diagnosis varies with the type of test. I have been provided with written information about the detection rate, and/or my health care provider has discussed it with me in detail.
  - This test may not provide informative results for any number of reasons. Some of the reasons are: 1) the need to test other family members; 2) individual genetic variations; 3) technical reasons.
  - If both parents are tested, this test may give information about who is, or is not, the mother or father of a child. I agree to provide a family history to the best of my knowledge.
  - All tests are confidential and will be released only to the ordering physician or that physician's designated representative. I understand, however, that in some states I may have to disclose this information to third parties such as life, disability, health insurers or government agencies.
  - I agree to allow (my) (my child's) blood or tissue sample provided for genetic testing to be used for the purpose of diagnosis. I understand that if I agree, any information identifying (me) (my child) will be kept confidential.
  - **HIBM testing on minors:** I understand that it is the policy of this laboratory NOT to test minors for HIBM.
  - The risks from procedures to obtain blood or tissue samples, such as bruising, have been explained to me.
  - An additional blood or tissue sample may have to be obtained to complete the tests or if the results are inconclusive.
  - All samples are coded with unique identifying information to assure quality and, to the extent humanly possible, to prevent error.
  - I understand that samples will be stored securely in case re-testing is necessary. Samples are stored according to applicable Federal, State and professional regulations. If no regulation applies, samples will be stored according to lab policy and at the end of that time, the sample will be destroyed. I may ask that the sample be destroyed immediately after testing is completed.
- I request that the sample be destroyed immediately after testing. I understand that it will not be available if re-testing is required.
- I agree to have my samples used for research purposes if they are stripped of all identifiers.
- I *decline* to be tested for HIBM since it may identify me as being affected even before the onset of symptoms and treatment is not yet available. I understand that I will lose the benefit of determining my carrier status for this condition by checking this box.

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Signature of patient or legal guardian

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Date