Heart Institute Diagnostic Laboratory – Test Requisition

Patient label

The Heart Institute Diagnostic Laboratory
Cincinnati Children's Hospital Medical Center
240 Albert Sabin Way, S4.381
Cincinnati, OH 45229
Phone 513-803-1751
Fax 513-803-1748
Email HeartDx@cchmc.org

Specimen type:

☐ Heart Biopsy ☐ Other _____ Date Collected _____(MM/DD/YYYY)

Patient Information

First Name:_____ MI: ____ Last Name:_____ ☐ M ☐ F

Street Address: _____DOB _____

City, State, Zip Code:_____

Race:
- ☐ European Caucasian
- ☐ Native American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American

Ethnicity:
- ☐ Hispanic
- ☐ Askenazi Jewish
- ☐ Other _____

(check all that apply)

Viral PCR Analysis: Check the Test(s) Requested

- ☐ Virus Panel (includes all listed below)
- ☐ Adenovirus
- ☐ Cytomegalovirus
- ☐ Enterovirus
- ☐ Epstein-Barr Virus
- ☐ Parvovirus
- ☐ Respiratory Syncytial Virus
- ☐ Influenza A Virus
- ☐ Hepatitis C Virus
- ☐ Human Herpes Virus 6

Indication for Study (check all that apply)

- ☐ Cardiac Transplant Surveillance
- ☐ Suspected Acute Rejection
- ☐ Myocarditis Evaluation
- ☐ Suspected Maternal-Fetal Infection
- ☐ Other _____

Referring Physician Information

Physician Name: _____ Institution: _____

Specialty: _____ Phone: _____ Fax: _____

Address: _____City, State, Zip: _____

Email Address: _____

Genetic Counselor: _____ Phone: _____ Fax: _____

REQUIRED: Authorized Signature_____

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Payment Information

☐ Institution Name: _____Institution Code: _____

Bill to name: _____and/or Department: _____

Facility address: _____

Contact name: _____ Phone/Fax number: _____

☐ Self-Pay: ☐ Credit Card ☐ Check (Test will not be performed until payment is received)

Credit Card type: ☐ Mastercard ☐ Visa ☐ AMEX

Name (as it appears on credit card): _____Expiration Date: _____

Credit Card number: _____ 3 Digit Security Code: _____

Billing address: _____ Signature: _____

Sample Shipping Information

Send samples Monday through Thursday overnight to:

The Heart Institute Diagnostic Laboratory
Cincinnati Children's Hospital Medical Center
240 Albert Sabin Way, S4.381
Cincinnati, OH 45229

Samples in RNA*later* preferred (call for supply)

RNA*later* Solution: The specimen should be cut into slices no more than 0.5cm across, if necessary, and immediately placed in a minimum of ten sample volumes of RNA*later* solution (Qiagen Cat. #: 76154 or 76163). Samples in RNA*later* can be stored up to 7 days at 18-25 ° C or up to 4 weeks at 4°C and shipped at room temperature.

Snap-frozen Specimens: Tissue samples cut into slices no more than 0.5cm across should be immediately placed into a sterile collection tube and then snap–frozen by placing the tube in liquid nitrogen. Once the sample is completely frozen (10-15 minutes), it should be stored at -80°C, on dry ice, or in liquid nitrogen until processed. Alternatively, if liquid nitrogen is not available, the sample can be immediately frozen using a dry ice/alcohol bath. Specimens that are snap-frozen should be shipped on dry ice using an overnight courier service.