Cincinnati Children's

MOLECULAR GENETICS LABORATORY
For courier service and/or inquiries, please contact 513-636-4474 • Fax: 513-636-4373
www.cincinnatichildrens.org/moleculargenetics • Email: moleculargenetics@cchmc.org

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3333 Burnet Avenue, Room NRB 1013
Cincinnati, OH 45229

EXOME SEQUENCING TEST REQUISITION

All Information Must Be Completed Before Sample Can Be Processed

PATIENT INFORMATION

Patient Name: _____ , _____ , _____
Last First MI

Address: _____

_____

Home Phone: _____

MR# _____ Date of Birth: _____ / _____ / _____

Gender: ☐ Male ☐ Female

ETHNIC/RACIAL BACKGROUND (Choose All)

☐ European American (White) ☐ African-American (Black)

☐ Native American or Alaskan ☐ Asian-American

☐ Pacific Islander ☐ Ashkenazi Jewish ancestry

☐ Latino-Hispanic _____
(specify country/region of origin)

☐ Other _____
(specify country/region of origin)

BILLING INFORMATION (Choose ONE method of payment)

☐ REFERRING INSTITUTION

Institution: _____

Address: _____

City/State/Zip: _____

Accounts Payable Contact Name: _____

Phone: _____

Fax: _____

Email: _____

☐ COMMERCIAL INSURANCE*

Insurance can only be billed if requested at the time of service.

Policy Holder Name: _____

Gender: _____ Date of Birth _____ / _____ / _____

Authorization Number: _____

Insurance ID Number: _____

Insurance Name: _____

Insurance Address: _____

City/State/Zip: _____

Insurance Phone Number: _____

*** PLEASE NOTE:**

- We will not bill Medicaid, Medicaid HMO, or Medicare except for the following: CCHMC Patients, CCHMC Providers, or Designated Regional Counties.
- Commercial Insurance Precertification will be performed for exome sequencing. Test(s) will not be started until authorization is obtained.
- If you have questions, please call 1-866-450-4198 for complete details.

REFERRING PHYSICIAN

Physician Name (print): _____

Address: _____

Phone: (_____) _____ Fax: (_____) _____ Email: _____

Genetic Counselor/Lab Contact Name: _____

Phone: (_____) _____ Fax: (_____) _____ Email: _____

_____ Date: ____/ ____/ ____

Referring Physician Signature (REQUIRED)

☐ Patient signed completed ABN

Medical Necessity Regulations: At the government's request, the Molecular Genetics Laboratories would like to remind all physicians that when ordering tests that will be paid under federal health care programs, including Medicare and Medicaid programs, that these programs will pay only for those tests the relevant program deems to be (1) included as covered services, (2) reasonable, (3) medically necessary for the treatment and diagnosis of the patient, and (4) not for screening purposes.

Cincinnati Children's

Patient Name: _____ Date of Birth: _____

SAMPLE/SPECIMEN INFORMATION

Has patient received a bone marrow transplant? ☐ Yes ☐ No

If yes, date of bone marrow transplant _____

Percent engraftment _____

Please send saliva kit and two cytobrushes. Note: STR analysis at an additional charge is required on cytobrushes and saliva samples obtained on all patients post BMT.

Specimen Type:

☐ Blood (> 3ml) ☐ DNA (>15 ug)

☐ Other_____

Proband: Specimen Date: _____ / _____ / _____ Time: _____

Specimen Amount: _____

DRAWN BY: _____

*Phlebotomist must initial tube of specimen to confirm sample identity

Each test requires 3 mL of whole blood in EDTA tube. Please call before sending other sample types.

Mother: Name: _____

Date of Birth: _____ / _____ / _____

Specimen Date: _____ / _____ / _____ Time: _____

Specimen Amount: _____ DRAWN By: _____

Father: Name: _____

Date of Birth: _____ / _____ / _____

Specimen Date: _____ / _____ / _____ Time: _____

Specimen Amount: _____ DRAWN By: _____

Other: Name: _____

Date of Birth: _____ / _____ / _____

Relationship to proband: _____

Specimen Date: _____ / _____ / _____ Time: _____

Specimen Amount: _____ DRAWN By: _____

Please use the space on the last page if needed.

CLINICAL EXOME SEQUENCING TEST REQUESTED

☐ Family trio (proband and two family members)

☐ Proband only

☐ Additional family member; please provide the proband's full name and birthdate:

Proband's full name: _____

Birthdate: _____ / _____ / _____

Checklist of items to include

☐ Proband's sample

☐ Maternal sample (for trio testing)

☐ Paternal sample (for trio testing)

☐ Other family member's sample (following discussion with laboratory)

☐ Test requisition (all billing and clinical information must be completed)

☐ Signed informed consent form

☐ Family history and pedigree

☐ Detailed patient clinical history/clinical summary or notes

☐ Summary of previous genetic test results

☐ Letter of medical necessity stating impact of whole exome sequencing results on medical management

Please include all information with sample(s) or fax to 513-636-4373.

CLINICAL HISTORY

Complete clinical information is critical to interpretation of exome sequencing results

Please indicate the presence of and describe the symptoms found in the patient and other family members. In addition, please submit the proband's clinical summary, relevant medical records and summary of previous test results.

Proband's working diagnosis: _____

Congenital anomalies (specify): _____

_____

_____

_____

Dysmorphic features (specify:) _____

_____

_____

_____

Previous diagnostic testing (please include reports, when available)

☐ Chromosome/FISH analysis _____

☐ Microarray _____

☐ Single gene testing _____

☐ Radiologic studies (MRI, CT, Xrays) _____

☐ Muscle/skin biopsy _____

☐ Metabolic testing _____

☐ Other relevant results: _____

_____

_____

_____

_____

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Patient Name: _____ Date of Birth: _____

CLINICAL HISTORY, CONTINUED

Please check all that apply and specify in the space provided. If family member is similarly affected, please indicate relation to proband.

Prenatal/Perinatal History

Proband	Family	
☐	☐	Intrauterine growth retardation _____
☐	☐	Prematurity/postmaturity _____
☐	☐	Poly/oligohydramnios _____
☐	☐	Maternal complications of pregnancy _____
☐	☐	Other _____

General History

Proband	Family	
☐	☐	Failure to thrive _____
☐	☐	Obesity/overgrowth/tall stature _____
☐	☐	Postnatal growth retardation/short stature _____
☐	☐	Developmental delay _____
		☐ Gross motor ☐ Fine motor ☐ Speech
☐	☐	Intellectual disability _____
☐	☐	Developmental regression _____
☐	☐	Autism/autism spectrum disorder _____
☐	☐	Psychiatric disorder _____
☐	☐	Behavioral disorder _____
☐	☐	Cancer Age of onset _____ Type _____
☐	☐	Sudden infant death / Sudden unexplained death
☐	☐	Other _____

Review of Systems

Proband	Family	
		Cardiovascular findings
☐	☐	Arrhythmia/conduction defect
☐	☐	Cardiomyopathy
☐	☐	Congenital heart defect (specify _____)
☐	☐	Vascular abnormalities
☐	☐	Others: _____
		Craniofacial/Ophthalmalogic/Auditory findings
☐	☐	Blindness
☐	☐	Cataract
☐	☐	Cleft palate / cleft lip
☐	☐	Coloboma
☐	☐	Craniosynostosis
☐	☐	Dysmorphic facial features
☐	☐	External ear malformation
☐	☐	Glaucoma
☐	☐	Hearing loss
☐	☐	Hemangioma
☐	☐	Hemifacial microsomia
☐	☐	Macrocephaly
☐	☐	Microcephaly
☐	☐	Retinal disorder
☐	☐	Vascular malformation
☐	☐	Others: _____
		Dermatologic findings
☐	☐	Alopecia
☐	☐	Angiokeratoma
☐	☐	Blistering of skin or mucosa
☐	☐	Cafe au lait spots
☐	☐	Hypopigmentation/ hyperpigmentation
☐	☐	Nail dysplasia
☐	☐	Rash/dermatitis/eczema
☐	☐	Others: _____

Proband	Family	
		Endocrine disorders
☐	☐	Adrenal abnormality
☐	☐	Diabetes type 1
☐	☐	Growth hormone abnormality
☐	☐	Sex hormone abnormality
☐	☐	Thyroid disease
☐	☐	Others: _____
		Gastrointestinal findings
☐	☐	Abnormal liver function
☐	☐	Achalasia
☐	☐	Acute liver failure
☐	☐	Bile duct proliferation
☐	☐	Biliary atresia
☐	☐	Cirrhosis
☐	☐	Chronic constipation
☐	☐	Chronic diarrhea
☐	☐	Congenital anomaly (specify _____)
☐	☐	Hepatomegaly
☐	☐	Jaundice
☐	☐	Liver cysts
☐	☐	Others: _____
		Genitourinary findings
☐	☐	Abnormal renal function (specify _____)
☐	☐	Ambiguous genitalia
☐	☐	Congenital genital anomaly (specify _____)
☐	☐	Obstructive renal disease
☐	☐	Renal hypoplasia/agenesis/dysgenesis
☐	☐	Renal cysts
☐	☐	Renal morphological anomalies (such as horseshoe kidney)
☐	☐	Sex reversal
☐	☐	Undescended testicles
☐	☐	Others: _____
		Hematologic findings
☐	☐	Anemia
☐	☐	Bone marrow failure
☐	☐	Excessive bruising
☐	☐	Hematomas
☐	☐	Leukemia/lymphoma
☐	☐	Leukopenia/neutropenia
☐	☐	Splenomegaly
☐	☐	Thrombosis
☐	☐	Thrombocytopenia/small platelets
☐	☐	Others: _____
		Immunologic/allergic findings
☐	☐	Allergies (specify _____)
☐	☐	Autoimmune disorders
☐	☐	Diffuse inflammation
☐	☐	Enlarged lymph nodes
☐	☐	Fevers
☐	☐	Recurrent, unusual or difficult to treat infections
		☐ viral ☐ bacterial ☐ fungal
☐	☐	Small lymph nodes and/or tonsils
☐	☐	Thymic hypoplasia
		Neuromuscular findings
☐	☐	Abnormal movements
☐	☐	Ataxia
☐	☐	Exercise intolerance/fatigue
☐	☐	Headaches/migraines
☐	☐	Hypertonia
☐	☐	Hypotonia
☐	☐	Neuropathy
☐	☐	Seizure / epilepsy
☐	☐	Stroke/stroke like episodes
☐	☐	Torticollis
☐	☐	Others: _____

Cincinnati Children's

Patient Name: _____ Date of Birth: _____

CLINICAL HISTORY, CONTINUED

Proband	Family	Skeletal findings
☐	☐	Arachnodactyly
☐	☐	Bone malformation
☐	☐	Clinodactyly
☐	☐	Disproportionate short limbs
☐	☐	Joint contractures
☐	☐	Kyphosis
☐	☐	Polydactyly
☐	☐	Scoliosis
☐	☐	Short stature, proportionate
☐	☐	Short stature, disproportionate
☐	☐	Syndactyly
☐	☐	Vertebral anomaly
☐	☐	Others: _____

ICD-9 Code: _____

Differential Diagnosis: _____

_____

_____

Additional Suspected Genes or Pathways: _____

_____

_____

Additional clinical info:

_____

_____

_____

FAMILY HISTORY

Parental consanguinity ☐ Yes ☐ No

Please draw or attach patient's three generation pedigree: