HEART INSTITUTE DIAGNOSTIC LABORATORY- ARRHYTHMIA TEST REQUISITION

Patient label	Cincinnati Children's Hospital Medical Center 240 Albert Sabin Way, Room S4.381 Cincinnati, OH 45229-3039 Phone: 513-803-1751 Fax: 513-803-1748

Specimen type: (MM/DD/YYYY)

☐ Blood ☐ DNA ☐ Other _____ Date Collected _____

PATIENT INFORMATION

First Name_____ MI _____ Last Name_____ ☐ M ☐ F ☐ Unknown
DOB _____ Street Address _____
City, State, Zip Code _____

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

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

(check all that apply)

GENE TEST TO BE PERFORMED

- ☐ CASQ2 Sequencing
- ☐ CAV3 Sequencing
- ☐ KCNJ2 Sequencing
- ☐ Long QT Syndrome Panel (KCNJ2, CAV3)
- ☐ Arrhythmia (Other) Panel (CASQ2, DES, KCNJ2)

☐ Known Familial Mutation Test
Gene_____
Mutation_____
Name of Proband_____
Relationship to Proband_____
Please provide copy of report if testing done at another laboratory.

CLINICAL INFORMATION

Clinical Features – Arrhythmia (check all that apply)

- ☐ Periodic paralysis
- ☐ Syncope
- ☐ Palpitations
- ☐ Dysmorphic features
  - ☐ Hypertelorism
  - ☐ Syndactyly
  - ☐ Short stature
  - ☐ Scoliosis
- ☐ Learning difficulties
- ☐ Conduction system disease
  - ☐ WPW
  - ☐ Prolonged QT interval
  - ☐ AV block _____
  - ☐ Ventricular arrhythmias

Additional Features:
- ☐ Cardiomyopathy
  - ☐ HCM
  - ☐ DCM
  - ☐ RCM
  - ☐ LVNC

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Family History ☐ Family History ☐ No Family History ☐ Patient adopted

List affected family members _____

Pedigree:

Paternal ethnicity:_____

Maternal ethnicity:_____

Consanguinity ☐ Yes ☐ No

TEST INDICATION

☐ Positive Family History ☐ Suspected Diagnosis

☐ Other_____

REFERRING PHYSICIAN INFORMATION

Physician Name_____ Institution_____

Specialty _____ Phone/Fax_____

Address _____City, State, Zip _____

Email Address _____

Contact Person (i.e. Genetic Counselor)_____Phone _____Fax _____

Fax duplicate reports to_____

REQUIRED: Physician Signature_____

HEART INSTITUTE DIAGNOSTIC LABORATORY-PAYMENT INFORMATION

Patient label	Cincinnati Children's Hospital Medical Center 240 Albert Sabin Way, Room S4.381 Cincinnati, OH 45229-3039 Phone: 513-803-1751 Fax: 513-803-1748

PATIENT INFORMATION

First Name_____ MI _____ Last Name_____ ☐ M ☐ F ☐ Unknown

DOB _____ Street Address _____

City, State, Zip Code _____

ONE OF THE TWO FOLLOWING BILLING OPTIONS MUST BE INDICATED

The Patient Pay option must include payment with sample.

☐ Referring Facility_____

Bill to name_____ and/or Department_____

Facility address_____

Contact name _____ Phone number_____

Institution code _____ Fax number_____

☐ Patient Pay ☐ Credit card ☐ Check

Name (as it appears on credit card)_____ Expiration Date _____

Credit Card Type ☐ Visa ☐ Mastercard ☐ Other _____

Credit Card Number _____ 3 Digit Security Code _____