HEART INSTITUTE DIAGNOSTIC LABORATORY-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

☐ Heterotaxy V1 Panel (4 genes)
CFC1, FOXH1, NODAL, ZIC3

☐ Heterotaxy V2 Panel (17 genes)
ACRV2, BCL9L, CCDC11, CFC1, CRELD1, DNAH11, DNAH5, FOXH1 GATA6, GDF1, GJA1, LEFTY2, NAT10, NKX2.5, NODAL, SHROOM3, ZIC3

☐ CFC1 Sequencing
☐ FOXH1 Sequencing
☐ NKX2.5 Sequencing
☐ NODAL Sequencing
☐ ZIC3 Sequencing

☐ Heterotaxy V1 Reflex Panel (13 genes)
ACRV2, BCL9L, CCDC11, CRELD1, DNAH11, DNAH5, GATA6, GDF1, GJA1, LEFTY2, NAT10, NKX2.5, SHROOM3
*For patients already tested through the HIDL

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

TEST INDICATION

- ☐ Congenital heart disease
- ☐ Arrhythmia
- ☐ Limb or hand anomaly
- ☐ Other_____
- ☐ Positive family history
- ☐ Situs anomalies (organ reversal or abnormal position)
- ☐ Dysmorphic features

(check all that apply)

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: Authorized Signature_____

HETEROTAXY SYNDROME
DISEASE SPECIFIC REQUISITION FORM

Name: _____

DOB: _____ / _____ / _____ (MM/DD/YY)

CLINICAL INFORMATION

Clinical Features – Heterotaxy syndrome (check all that apply)

Situs:
- ☐ Solitus
- ☐ Ambiguous
- ☐ Inversus totalis

Abdomen/Gastrointestinal:
- ☐ Abdominal situs inversus
- ☐ Bile duct hypoplasia/biliary atresia
- ☐ Gallbladder abnormalities
- ☐ Malrotation of the gut
- ☐ Spleen abnormality
  - ☐ asplenia
  - ☐ polysplenia
- ☐ imperforate anus
- ☐ renal anomaly

Skeletal:
- ☐ Vertebral abnormalities
- ☐ Rib abnormalities
- ☐ Scoliosis

Chest/Airway:
- ☐ Lungs
  - ☐ bilateral bilobed
  - ☐ bilateral trilobed
- ☐ Bronchi
  - ☐ eparterial
  - ☐ hyparterial
- ☐ Bronchiectasis
- ☐ Sinusitis
- ☐ Abnormal cilia biopsy

Cardiac:
- ☐ Position
  - ☐ levocardia
  - ☐ mesocardia
  - ☐ dextrocardia
- ☐ Vessels
  - ☐ SVC abnormality
  - ☐ IVC abnormality
  - ☐ Pulmonary veins
    - ☐ TAPVR
    - ☐ PAPVR
- ☐ Atria
  - ☐ SA node
    - ☐ bilateral
    - ☐ absent
  - ☐ ASD
  - ☐ AV Canal
- ☐ Ventricles
  - ☐ Single ventricle
  - ☐ VSD
- ☐ Great Arteries/conotruncal
  - ☐ aortic arch abnormality
  - ☐ d-TGA
  - ☐ l-TGA
  - ☐ DORV
  - ☐ pulmonary outflow
    - ☐ subpulmonic stenosis
    - ☐ pulmonic atresia
  - ☐ left sided outflow
    - ☐ mitral stenosis
    - ☐ aortic stenosis
    - ☐ aortic coarctation
  - ☐ tetralogy of Fallot

Additional Features:

Family History ☐ Family History ☐ No Family History ☐ Patient Adopted

List affected family members _____

Pedigree:

Paternal ethnicity:_____

Maternal ethnicity:_____

Consanguinity ☐ Yes ☐ No

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 FOLLOWING BILLING OPTIONS MUST BE INDICATED.

The Patient Pay option must include payment with the sample.
The Direct Insurance Billing option must include a copy of the insurance card with the requisition.

☐ **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 _____

☐ **Insurance Company***_____

Subscriber ID: _____ Group Name/Number:_____

Subscriber Name, Address and Phone number: _____

_____

Ordering Physician Name and NPI #: _____

Diagnosis Code(s):_____

*Please note, Cincinnati Children's Hospital Medical Center cannot bill out of state Medicaid.