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

- ☐ Marfan syndrome panel (FBN1, TGFBR1, TGFBR2)
- ☐ Fibrillin 1 (FBN1) Sequencing
- ☐ TGF-Beta Receptor 1 (TGFBR1) Sequencing
- ☐ TGF-Beta Receptor 2 (TGFBR2) Sequencing
- ☐ 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

- ☐ Cardiac involvement
- ☐ Cleft palate or bifid uvula
- ☐ Craniosynostosis
- ☐ Positive family history
- ☐ Other_____
- ☐ Ocular involvement
- ☐ Skeletal involvement
- ☐ Vascular involvement (arterial aneurysm or tortuosity)

(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_____

MARFAN SYNDROME AND LOEYS-DIETZ SYNDROME
DISEASE SPECIFIC REQUISITION FORM

Name: _____

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

DIAGNOSIS

Known or Suspected Clinical Diagnosis

☐ Marfan syndrome ☐ Loeys-Dietz

Age at diagnosis _____ ICD-9 Code: ☐ 759.82 (Marfan) ☐ Other_____

CLINICAL INFORMATION

Clinical Features – Marfan syndrome (check all that apply)

Cardiac:

☐ Aortic dilation (ascending)
Sinotubular junction _____ cm

☐ Aortic dissection
- ☐ Ascending thoracic
- ☐ Descending thoracic
- ☐ Abdominal

☐ Mitral valve prolapse
- ☐ Regurgitation

☐ Pulmonary artery dilation

☐ Mitral annulus calcification (age <40)

☐ Other _____

Dura:

☐ Dural ectasia

Pulmonary:

☐ Spontaneous pneumothorax

☐ Apical blebs

Skin

☐ Striae atrophicae

☐ Recurrent incisional hernia

Skeletal

☐ Pectus carinatum

☐ Pectus excavatum
- ☐ Surgical repair

☐ Wrist AND thumb sign

☐ Reduced upper:lower segment OR arm span:height >1.05

☐ Scoliosis - degree _____

☐ Reduced elbow extension

☐ Pes planus

☐ Protrusio acetabuli

☐ Joint hypermobility
Beighton score_____

☐ High arched palate

☐ Facial findings _____

Ocular:

☐ Ectopia Lentis

☐ Flat cornea

☐ Increased length of globe

☐ Hypoplastic iris OR ciliary muscle (decreased miosis)

Diagnostic criteria ☐ Clinical diagnostic criteria met ☐ Suggestive features do not meet clinical criteria

Additional Features – Loeys-Dietz syndrome (check all that apply)

☐ Craniosynostosis ☐ Cleft palate OR bifid uvula ☐ Talipes equinovarus ☐ Easy bruising

☐ Vascular findings: including arterial aneurysms and dissection

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 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 _____