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

- ☐ NKX2.5 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

- ☐ Congenital heart disease
- ☐ Arrhythmia
- ☐ Thyroid abnormality
- ☐ Other_____
- ☐ Positive family history
- ☐ Situs anomalies (organ reversal or abnormal position)

(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_____

NXK2.5 MUTATION
DISEASE SPECIFIC REQUISITION FORM

Name: _____

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

CLINICAL INFORMATION
NKX2.5

Cardiac:
- ☐ Atrial septal defect
- ☐ Atrial isomerism
- ☐ Ventricular septal defect
- ☐ Tetralogy of Fallot
- ☐ Heterotaxy
- ☐ Other _____

Arrhythmia/Conduction system:
- ☐ Bradycardia
- ☐ AV block
- ☐ Atrial fibrillation
- ☐ Other _____

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 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 _____