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

- ☐ SURF1 Sequencing
- ☐ SCO2 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

- ☐ Cardiomyopathy
- ☐ Encephalopathy
- ☐ Leigh syndrome
- ☐ Lactic acidosis
- ☐ Mitochondrial Complex IV (cytochrome c oxidase-COX deficiency)
- ☐ Positive family history
- ☐ Other_____

(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_____

SURF1 MUTATION
DISEASE SPECIFIC REQUISITION FORM

Name: _____

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

CLINICAL INFORMATION
SURF1 or SCO2

Cardiac:
- ☐ Cardiomyopathy
  Type:_____
- ☐ Arrhythmia
  Type:_____

Neuromuscular:
- ☐ Muscle weakness
- ☐ Exercise intolerance
- ☐ Ophthalmoparesis, CPEO

Ophthalmologic:
- ☐ Ptosis
- ☐ Strabismus

Central nervous system:
- ☐ Developmental delay/MR
- ☐ Hypotonia
- ☐ Encephalopathy
- ☐ Seizures
- ☐ Spasticity
- ☐ Ataxia

Labs, pathology, and imaging:
- ☐ Lactic acidosis
- ☐ Elevated pyruvate
- ☐ Abnormal brain imaging
  Findings:_____
- ☐ Abnormal muscle biopsy
  Findings:_____
- ☐ COX deficiency
- ☐ Other:_____

Other Clinical:
- ☐ Failure to thrive
- ☐ Microcephaly
- ☐ Dysmorphic features
- ☐ Stridor/respiratory distress/respiratory failure

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 _____