# HEART INSTITUTE DIAGNOSTIC LABORATORY-TEST REQUISITION

| Patient label | Cincinnati Children's Hospital Medical Center<br>240 Albert Sabin Way, Room S4.381<br>Cincinnati, OH 45229-3039<br>Phone: 513-803-1751 Fax: 513-803-17 48 |
|---|---|

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

- ☐ TBX5 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
- ☐ 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_____

**HOLT ORAM SYNDROME/TBX5 MUTATION**
**DISEASE SPECIFIC REQUISITION FORM**

Name: _____

DOB: / / (MM/DD/YY)

## CLINICAL INFORMATION

### Clinical Features – Holt Oram syndrome

*Limb:*
- ☐ Unilateral defect
- ☐ Bilaterally symmetric defect
- ☐ Bilaterally asymmetric defect
- ☐ Triphalangeal thumb(s)
- ☐ Absent thumb(s)
- ☐ Carpal bone abnormality
- ☐ Thenar abnormality
- ☐ Radial abnormality including absent radius
- ☐ Phocomelia

*Cardiac:*
- ☐ Atrial septal defect
- ☐ Atrial isomerism
- ☐ Ventricular septal defect

*Conduction system/other:*
- ☐ Bradycardia
- ☐ AV block
- ☐ Atrial fibrillation
- ☐ Pulmonary hypertension

**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<br>240 Albert Sabin Way, Room S4.381<br>Cincinnati, OH 45229-3039<br>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 _____