HEART INSTITUTE DIAGNOSTIC LABORATORY- CARDIOMYOPATHY 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	
GENE TEST TO BE PERFORMED		
☐ Dilated Cardiomyopathy Panel (DES, LAMP2, LDB3, LMNA, MYBPC3, MYH7, MYL2, MYL3, TAZ, TNNT2) ☐ Hypertrophic Cardiomyopathy Panel (CAV3, LAMP2, LDB3, MYBPC3, MYH7, MYL2, MYL3, SCO2, SURF1, TNNT2) ☐ Muscular Dystrophies with CM (LMNA,CAV3, EMD, LDB3, DES) ☐ Atrioventricular Block Panel	☐ Individual Gene Full Mutation Test  Gene  Known Familial Mutation Test Gene Mutation Name of Proband Relationship to Proband Please provide copy of report if testing	
(LMNA, DES, EMD, NKX2.5)	done at another laboratory.	
CLINICAL INFORMATION		
Clinical Features – Card  Devices/surgeries  ICD  Pacemaker  Transplant  Skeletal muscle involvement  Learning difficulties  Cardiac findings  Left ventricular hypertrophy  Asymmetric septal hypertrophy  Concentric hypertrophy  Ventricular enlargement/dilation	Uventricular enlargement/dilation  □ Left ventricular non-compaction  □ Reduced ejection fraction/endocardial shortening fraction  □ Atrial enlargement	

Clinical diagnosis:  Cardiomyopathy  HCM  DCM  RCM  LVNC  Danon disease  Barth syndrome  Leigh syndrome  Age at diagnosis	☐ Conduction system disease ☐ WPW ☐ AV block ☐ Other ☐ Other systemic involvement	
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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	
Family History		
Paternal ethnicity:  Maternal ethnicity:  Consanguinity  Yes  No		
TEST INDICATION		
☐ Positive Family History ☐ Other	Suspected Diagnosis	
REFERRING PHYSICIAN INFORMATION		
Physician Name	Institution	
	Phone/Fax	
Address	City, State, Zip	
Email Address		
Contact Person (i.e. Genetic Counselor)	PhoneFax	
Fax duplicate reports to  Required: Authorized Signature		

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	
DOB Street Ac	ddress	
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 care	d)Expiration Date	
Credit Card Type □ Visa	☐ Mastercard ☐ Other	
Credit Card Number	3 Digit Security Code	