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

- ☐ LDB3 Sequencing
- ☐ LMNA Sequencing
- ☐ MYBPC3 Sequencing
- ☐ MYH7 Sequencing
- ☐ MYL2 Sequencing
- ☐ MYL3 Sequencing
- ☐ TAZ Sequencing
- ☐ TNNT2 Sequencing

☐ Left Ventricular Noncompaction Panel
(all genes listed above)

☐ 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
- ☐ Arrhythmia
- ☐ Conduction disease
- ☐ Other_____
- ☐ Positive family history
- ☐ Skeletal myopathy

(check all that apply)

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_____

LEFT VENTRICULAR NONCOMPACTION
DISEASE SPECIFIC REQUISITION FORM

Name: _____

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

CLINICAL INFORMATION

Clinical Features – Left ventricular noncompaction (check all that apply)

Cardiac:

- ☐ Left ventricular noncompaction
- ☐ Hypertrophic cardiomyopathy
- ☐ Dilated cardiomyopathy
- ☐ Restrictive cardiomyopathy
- ☐ Arrhythmia_____
- ☐ Conduction disease_____

Other:

- ☐ 3-methylglutaconic aciduria
- ☐ Growth delay
- ☐ Skeletal myopathy
- ☐ Decreased total cholesterol
- ☐ Neutropenia
- ☐ Lipodystrophy
- ☐ Progeria
- ☐ Muscular dystrophy
- ☐ Thromboembolism

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 _____