HEART INSTITUTE DIAGNOSTIC LABORATORY- THORACIC AORTIC ANEURYSM

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

- ☐ ACTA2 Sequencing
- ☐ MYH11 Sequencing
- ☐ FBN1 Sequencing
- ☐ TGFBR1 Sequencing
- ☐ TGFBR2 Sequencing
- ☐ SKI Sequencing

☐ Thoracic Aortic Aneurysm Panel
(ACTA2, CBS, COL3A1, FBN1, FBN2, FLNA, MYH11, MYLK, SKI, SLC2A10, SMAD3, TGFB2, TGFBR1, TGFBR2)

☐ Known Familial Mutation Test
Gene_____
Mutation_____
Name of Proband_____
Relationship to Proband_____

Please provide copy of report if testing done at another laboratory.

CLINICAL INFORMATION

Clinical Features – Aortopathy (check all that apply)

- ☐ Congenital heart disease
  - ☐ Bicuspid aortic valve
  - ☐ Patent ductus arteriosus
  - ☐ Other _____
- ☐ Aortic dilation
  - ☐ Sinuses of Valsalva (root)
  - ☐ Ascending aorta
  - ☐ Descending aorta
- ☐ Aortic dissection

Additional Features:
- ☐ Livedo reticularis
- ☐ Iris flocculi
- ☐ Inguinal hernia
- ☐ Scoliosis
- ☐ Other concern for connective tissue disorder _____

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 ☐ Family History ☐ No Family History ☐ Patient adopted

List affected family members _____

Pedigree:

Paternal ethnicity:_____

Maternal ethnicity:_____

Consanguinity ☐ Yes ☐ No

TEST INDICATION

☐ Positive Family History ☐ Suspected Diagnosis

☐ Other_____

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_____

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 FOLLOWING BILLING OPTIONS MUST BE INDICATED.

The Patient Pay option must include payment with the sample.
The Direct Insurance Billing option must include a copy of the insurance card with the requisition.

☐ **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 _____

☐ **Insurance Company***_____

Subscriber ID: _____ Group Name/Number:_____

Subscriber Name, Address and Phone number: _____

_____

Ordering Physician Name and NPI #: _____

Diagnosis Code(s):_____

*Please note, Cincinnati Children's Hospital Medical Center cannot bill out of state Medicaid.