



PRIMARY IMMUNODEFICIENCIES TESTING REQUISITION

MOLECULAR GENETICS LABORATORY

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For courier service and/or inquiries, please contact: (513) 636-4474 / Fax: (513) 636-4373

PATIENT INFORMATION

PATIENT NAME:
ADDRESS:
GENDER: M \_\_\_ F \_\_\_ DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_
PHONE:
MEDICAL RECORD #:
ETHNICITY: African-American, Asian, Caucasian, Hispanic, Native American, Other
COUNTRY OF ORIGIN:
PARENTAL CONSANGUINITY: Yes \_\_\_ No \_\_\_

TEST REQUESTED

- Autoimmune lymphoproliferative syndrome (FAS-TNFRSF6)
Familial Hemophagocytic lymphohistiocytosis
IPEX syndrome (FOXP3)
Wiskott-Aldrich Syndrome (WAS)
X-linked hyper IgM immunodeficiency (XHIM-CD40LG)
X-linked lymphoproliferative disease
X-linked severe combined immunodeficiency (X-SCID-IL2RG)

\* Family-specific mutation analysis (by prior arrangement only).

INDICATION

- Mutation detection in suspected affected patient
Carrier testing
Prenatal diagnosis (by prior arrangement only)

PRESENTING SYMPTOMS/HISTORY

- Recurrent infections, Life-threatening infections, Eczema, Diarrhea, Thrombocytopenia, Other (please specify)

PEDIGREE OR FAMILY HISTORY

SPECIMEN DRAW DATE:
(No less than 3 mls in purple top EDTA tube)

SPECIMEN TYPE: Blood, cytobrush, Other (Specify):

Phlebotomist must initial tube of blood to confirm sample identity.

DIAGNOSIS/ICD-9 CODE:

REFERRING PHYSICIAN

Name:
Address:
Phone: Fax:
Email:

PHYSICIAN SIGNATURE (REQUIRED)

DATE

GENETIC COUNSELOR / REFERENCE LAB

Name:
Address:
Phone: Fax:
Email:

BILLING INFORMATION

(complete ONE only or attach)

1. Check enclosed, Money Order, CC (AMX/MC/VISA/DISCOVER)
Account #: Exp date
Cardholder name:
Cardholder signature:

2. Referring Institution or MD
Institution Name:
Billing Address:
City, State, Zip:
Financial Contact:
Email (required):
Phone #: Fax #:

3. Insurance
HMO, PPO, Commercial Ins, Medicaid - provide front/back copy of insurance card.

Policyholder's Information

Name: D.O.B.
SS#: Gender: M / F Authorization #:
Relationship to Patient:
Insurance Name:
Insurance ID#: Group #:
Insurance Address:
Insurance City, State, Zip:
Insurance Phone #:

Medical Necessity Regulations: At the government's request, the Cytogenetics and Molecular Genetics Laboratories would like to remind all physicians that when ordering tests that will be paid under federal health care programs, including Medicare and Medicaid programs, that these programs will pay only for those tests the relevant program deems to be included as covered services, (2) reasonable, (3) medically necessary for the treatment and diagnosis of the patient, and (4) not for screening purposes.

Check here if patient signed completed ABN

\*\*ALL INFORMATION MUST BE COMPLETED BEFORE SAMPLE CAN BE PROCESSED\*\*

Laboratory Use Only Date/Time Received: Received by: Specimen Container: # Tubes: