



Molecular Genetics Laboratory

Heritable Liver Disease Test Requisition

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Cincinnati, OH 45229

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

For information about other molecular tests:
www.cincinnatichildrens.org/moleculargenetics

PATIENT INFORMATION PATIENT NAME: _____, _____, _____ Last First MI ADDRESS: _____ <hr/> HOME PHONE: (_____) _____ MR # _____ GENDER: M _____ F _____ DATE OF BIRTH: ____/____/____	SAMPLE INFORMATION: SPECIMEN TYPE: <input type="checkbox"/> Blood <input type="checkbox"/> CVS <input type="checkbox"/> Cytobrush <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Cord Blood <input type="checkbox"/> Tissue (Specify): _____ <input type="checkbox"/> Other: _____ SPECIMEN DRAW DATE: ____/____/____ Time: _____ SPECIMEN AMOUNT: _____ All tests require >2 ml of blood in EDTA tube. DRAWN BY: _____ <small>*Phlebotomist must initial tube of specimen to confirm sample identity</small>
ETHNICITY (choose one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino	RACE (Choose ALL that apply): <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other (specify) _____
TEST REQUESTED – check box(es) to order testing. For reflex testing, indicate order in the space provided (eg, 1,2,3). <input type="checkbox"/> JaundiceChip Re-sequencing Array <small>Which analyzes all of the following: JAG1- Alagille syndrome, ATP8B1- PFIC1/FIC1 deficiency, ABCB11- PFIC2/BSEP deficiency, ABCB4- PFIC3/MDR3 deficiency, SERPINA1- α1-antitrypsin deficiency</small> OR ORDER THE FOLLOWING TESTS INDIVIDUALLY <input type="checkbox"/> Alagille syndrome (JAG1) full sequence analysis* <input type="checkbox"/> PFIC1/FIC1 deficiency (ATP8B1) full sequence analysis <input type="checkbox"/> PFIC2/BSEP deficiency (ABCB11) full sequence analysis <input type="checkbox"/> PFIC3/MDR3 deficiency (ABCB4) full sequence analysis <input type="checkbox"/> α1-antitrypsin deficiency (SERPINA1) full sequence analysis <input type="checkbox"/> α1-antitrypsin (SERPINA1) SNP assay for PI*Z and S alleles <small>* JAG1 full gene sequence analysis is recommended for patients with suspected Alagille syndrome.</small>	Family-Specific Mutation Analyses (by prior arrangement only)** <input type="checkbox"/> JAG1 family specific mutation analysis <input type="checkbox"/> SERPINA1 family specific mutation analysis <input type="checkbox"/> ATP8B1 family specific mutation analysis <input type="checkbox"/> ABCB11 family specific mutation analysis <input type="checkbox"/> ABCB4 family specific mutation analysis <small>** Please provide name and birth date of previously tested family member or attach copy of proband's genetic test result.</small> Proband's name: _____ DOB: _____
TEST INDICATIONS <input type="checkbox"/> Diagnosis in symptomatic patient <input type="checkbox"/> Carrier testing <input type="checkbox"/> Presymptomatic diagnosis of at-risk sibling <input type="checkbox"/> Prenatal testing (by previous arrangement only) <input type="checkbox"/> Family history of disease Please specify relationship (e.g.; cousin): _____	CLINICAL HISTORY (symptomatic patients only) <input type="checkbox"/> Suspected Alagille syndrome <ul style="list-style-type: none"> <input type="checkbox"/> liver disease <input type="checkbox"/> characteristic facial features <input type="checkbox"/> paucity of bile ducts <input type="checkbox"/> congenital heart disease <input type="checkbox"/> embryotoxon <input type="checkbox"/> vertebral body defect <input type="checkbox"/> Jaundice <input type="checkbox"/> Liver Transplant <input type="checkbox"/> Elevated GTP <input type="checkbox"/> Normal or low GTP <input type="checkbox"/> Elevated bilirubin <input type="checkbox"/> Paucity of bile ducts <input type="checkbox"/> Other symptoms _____
FAMILY HISTORY/PEDIGREE <input type="checkbox"/> Parental consanguinity	REFERRING PHYSICIAN INFORMATION Physician Name (print): _____ Address: _____ Phone: (____) _____ Fax: (____) _____ Email: _____ Genetic Counselor Name: _____ Phone: (____) _____ Fax: (____) _____ Email: _____ REFERRING PHYSICIAN SIGNATURE (REQUIRED) _____ DATE _____
Medical Necessity Regulations: At the government's request, the 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 (1) included as covered services, (2) reasonable, (3) medically necessary for the treatment and diagnosis of the patient, and (4) not for screening purposes.	
ALL INFORMATION MUST BE COMPLETED BEFORE SAMPLE CAN BE PROCESSED	

Laboratory Use Only- Date/Time Received:

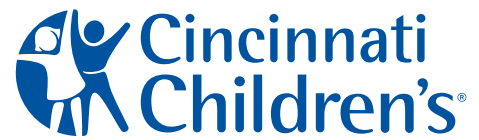
Received by:

Specimen Container:

of Tubes:

Billing Information

Patient Name Last/First
DOB



Cincinnati Children's Hospital
Medical Center
3333 Burnett Avenue
Cincinnati, OH
45229

Choose one method of payment

Patient Billing

- Check Enclosed Money Order Credit Card
(Visa, MC, AM.Exp., Disc.)

Credit Card Number
Card Holder Name
Expiration Date
Signature

Phone: 513-636-4474

Fax: 513-636-4373

www.cincinnatichildrens.org

Referring Institution or MD

Institution
Address
City/State/Zip
Contact Name
Phone
Fax
Email

Insurance / Policy Holder Information

Name	
DOB	Gender
Authorization Number	
Insurance Name	
Insurance Address	
City/State/Zip	
Insurance ID Number	
Group Number	
Insurance Phone Number	

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Patient signed completed ABN

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