

MOLECULAR GENETICS TEST REQUISITION FORM



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

<p>PATIENT INFORMATION</p> <p>PATIENT NAME: _____, _____, _____ <small style="margin-left: 100px;">Last</small> <small style="margin-left: 100px;">First</small> <small style="margin-left: 100px;">MI</small></p> <p>ADDRESS: _____ MR # _____ <small style="margin-left: 100px;">GENDER: M ___ F ___</small></p> <p>HOME PHONE: (____) _____ DATE OF BIRTH ____/____/____ <small style="margin-left: 150px;">mm/dd/yy</small></p>	<p>SAMPLE INFORMATION</p> <p>SPECIMEN TYPE: <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Blood <input type="checkbox"/> Bone Marrow <input type="checkbox"/> CVS <input type="checkbox"/> Buccal swab/brush <input type="checkbox"/> Cord Blood</p> <p><input type="checkbox"/> Tissue (Specify): _____ <input type="checkbox"/> Other (Specify): _____</p> <p>SPECIMEN DRAW DATE: ____/____/____ Time: _____ SPECIMEN AMOUNT: _____</p> <p style="text-align: center; color: red;">All tests require >3 mL of blood in EDTA tube.</p> <p>DRAWN BY: _____</p> <p style="text-align: center; color: red;">*Phlebotomist must initial tube of specimen to confirm sample identity</p>
<p>ETHNICITY (choose one)</p> <p><input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino</p> <p>Parental Consanguinity ___Y ___N</p>	<p>RACE (Choose ALL that apply):</p> <p><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) _____</p>

TEST REQUESTED

<p>All tests are performed by PCR-based sequence analysis of all coding exons and intron boundaries unless otherwise specified.</p> <p>Please refer to our website for test details.</p> <p>■ Genetic Pharmacology Services:</p> <p><input type="checkbox"/> CCHMC Psychiatry Panel <input type="checkbox"/> TPMT Genotype Analysis <input type="checkbox"/> Tamoxifen 2D6 Genotype Analysis <input type="checkbox"/> Warfarin (CYP2C9 and VKORC1) Genotype Analysis <input type="checkbox"/> Specify drug: _____ <small>(See http://gps.cchmc.org for list)</small></p> <p>■ Hearing Loss Molecular Testing (provide clinical data sheet & audiology report)</p> <p><input type="checkbox"/> Hearing Loss Panel Tier I <input type="checkbox"/> Hearing Loss Panel Tier II OR</p> <p><input type="checkbox"/> <i>GJB2</i> (connexin 26) <input type="checkbox"/> <i>GJB6</i> (connexin 30) <input type="checkbox"/> Mitochondrial mutation analysis <i>12SrRNA</i> & <i>tRNA^{ser(UCN)}</i> <input type="checkbox"/> <i>SLC26A4</i> (Pendrin) <input type="checkbox"/> <i>CDH23</i> (Usher 1D and nonsyndromic hearing loss) <input type="checkbox"/> <i>MYO7A</i> (Usher 1B and nonsyndromic hearing loss) <input type="checkbox"/> <i>OTOF</i> (auditory neuropathy and nonsyndromic hearing loss)</p> <p>■ Fatty Acid Oxidation Disorders*</p> <p><input type="checkbox"/> <i>ACADVL</i> (VLCAD) <input type="checkbox"/> <i>ACADM</i> (MCAD) <input type="checkbox"/> MCAD (K329E) genotyping only <input type="checkbox"/> MCAD (K329E) genotyping with reflex to full <i>ACADM</i> gene sequence analysis, if warranted</p> <p><small>*Please contact the Strauss Research Laboratory at 513-636-9287 for additional test offerings.</small></p>	<p>■ Immunodeficiency Testing</p> <p><input type="checkbox"/> <i>BIRC4/XIAP</i> (XLP2) <input type="checkbox"/> <i>CD40LG</i> (X-linked hyper IgM syndrome) <input type="checkbox"/> <i>CASP10</i> (ALPS2) <input type="checkbox"/> <i>ELA2</i> (severe congenital neutropenia/cyclic neutropenia) <input type="checkbox"/> <i>FASLG</i> (ALPS1b) <input type="checkbox"/> <i>FAS</i> (ALPS1) <input type="checkbox"/> <i>HAX1</i> (Kostmann syndrome) <input type="checkbox"/> <i>IL2RG</i> (X-linked severe combined immunodeficiency) <input type="checkbox"/> <i>FOXP3</i> (IPEX syndrome) <input type="checkbox"/> <i>MUNC13-4/UNC13D</i> (FHL3) <input type="checkbox"/> <i>PRF1</i> (FHL2) <input type="checkbox"/> <i>RAB27A</i> (Griscelli syndrome) <input type="checkbox"/> <i>SH2D1A</i> (XLP1) <input type="checkbox"/> <i>STX11</i> (FHL4) <input type="checkbox"/> <i>WAS</i> (Wiskott-Aldrich syndrome)</p> <p>■ Liver Disease Testing</p> <p><input type="checkbox"/> JaundiceChip Re-sequencing Array OR</p> <p><input type="checkbox"/> <i>ABCB4</i> (PFIC3/MDR3 deficiency) <input type="checkbox"/> <i>ABCB11</i> (PFIC2/BSEP deficiency) <input type="checkbox"/> <i>ATP8B1</i> (PFIC1/FIC1 deficiency) <input type="checkbox"/> <i>JAG1</i> (Alagille syndrome) <input type="checkbox"/> <i>SERPINA1</i> genotyping assay for PI*Z and PI*S alleles <input type="checkbox"/> <i>SERPINA1</i> (alpha-1-antitrypsin deficiency)</p> <p>■ Lysosomal Storage Disease Testing</p> <p><input type="checkbox"/> <i>GAA</i> (Pompe disease) <input type="checkbox"/> <i>GAA</i> (infantile Pompe disease)** <input type="checkbox"/> <i>GBA</i> (Gaucher disease) <input type="checkbox"/> Ashkenazi Panel (tests only N370S, L444P, 84GG, IVS2+1G>A) <input type="checkbox"/> <i>GLA</i> (Fabry disease) <input type="checkbox"/> <i>IDS</i> (Hunter disease; MPSII)</p> <p>** You must call 1-513-636-4474 to speak with a genetic counselor prior to ordering.</p>
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■ **Oncology Molecular Testing**

Molecular Analysis For Leukemia Translocation: by RT-PCR
(sample must be received within 48 hrs after drawing)

- BCR/ABL t(9:22)--(qualitative only)
- BCR/ABL (quantitative)
- JAK2
- PML-RARα t(15:17)—(qualitative only)
- NPM1 (quantitative)

■ **Other Testing**

- Bone Marrow Engraftment (BME by STR)

Please specify:

O Donor O Host (pre-transplant) O Host (post-transplant)

- Bone Marrow Engraftment (SCT-BME) for sub-cell type

(You must call 513-636-4685 to arrange prior to sample submission)

Specify cell type: _____

Please specify:

O Donor O Host (pre-transplant) O Host (post-transplant)

- Factor V (Leiden)
- Fragile X Syndrome (FMR1 – By PCR and Southern)
- Hereditary Hemochromatosis (HFE- C282Y and H63D)
- MECP2 (Rett syndrome)
- MTHFR_677 C>T and 1298 A>C
- Prader-Willi/Angelman Syndrome (by methylation specific PCR)
- Thrombophilic Polymorphism Panel (MTHFR-677C>T and 1298 A>C, Factor V- Leiden, Factor II-Prothrombin 20210, PAI-1)
- Prothrombin (Factor II) Genotype Analysis

■ **Other Services**

- DNA/RNA Processing and Storage –
(Call (513) 636-4474 to arrange)
- Maternal cell contamination
(by STR; required for all prenatal diagnostic testing)
- Twin zygosity (by STR)

■ **Family-specific mutation detection (for disorders listed)**

Please call 513-636-4474 to discuss any family-specific mutation analysis with genetic counselor prior to shipment.

Proband's name: _____

Proband's DOB: _____

Gene of interest: _____

Proband's mutation: _____

PEDIGREE OR SUMMARY OF FAMILY HISTORY

REFERRING PHYSICIAN INFORMATION:

Physician Name (print): _____

Address: _____

Email: _____

Genetic Counselor/Laboratory Name: _____

Phone: (_____) _____ Fax: (_____) _____

Email: _____

REFERRING PHYSICIAN SIGNATURE (REQUIRED) DATE

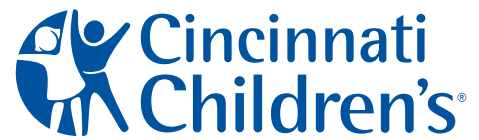
Medical Necessity Regulations: At the government's request, the Molecular Genetics Laboratories would like to remind all physicians that when ordering tests that will be paid under federal health care programs, including Medicare and Medicaid programs, that these programs will pay only for those tests 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****

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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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