MOLECULAR GENETICS, NEPHROLOGY AND CANCER
& BLOOD DISEASES INSTITUTE CLINICAL LABORATORIES

For test inquiries please call: **513-636-4530**
Fax: **513-803-5056**
Email: **nephclinicallab@cchmc.org**

Cincinnati Children's®
changing the outcome together

DENSE DEPOSIT DISEASE AND C3 GLOMERULONEPHRITIS TEST REQUISITION

All Information Must Be Completed Before Sample Can Be Processed

PATIENT INFORMATION

Patient Name: _____ , _____ , _____
Last *First* *MI*

Address: _____

_____

Home Phone: _____

MR# _____ Date of Birth _____ / _____ / _____
(month) *(day)* *(year)*

Gender: ☐ Male ☐ Female

ETHNIC/RACIAL BACKGROUND (Choose All)

☐ European American (White)
☐ African American (Black)
☐ Native American or Alaskan
☐ Asian American
☐ Pacific Islander
☐ Ashkenazi Jewish ancestry
☐ Latino/Hispanic _____
(specify country/region of origin)
☐ Other _____
(specify country/region of origin)

BILLING INFORMATION (Choose ONE method of payment)

☐ REFERRING INSTITUTION

Institution: _____

Address: _____

City/State/Zip: _____

Accounts Payable Contact Name: _____

Phone: _____

Fax: _____

Email: _____

☐ COMMERCIAL INSURANCE*

Insurance can only be billed if requested at the time of service.

Policy Holder Name: _____

Gender: _____ Date of Birth _____ / _____ / _____
(month) *(day)* *year)*

Authorization Number: _____

Insurance ID Number: _____

Insurance Name: _____

Insurance Address: _____

City/State/Zip: _____

Insurance Phone Number: _____

***PLEASE NOTE:**

- We will not bill Medicaid or Medicaid HMO except for the following: CCHMC Patients, CCHMC Providers, or Designated Regional Counties.
- Commercial Insurance Precertification for genetic testing available upon request. Test(s) will not be started until authorization is obtained.
- If you have questions, please call 1-866-450-4198 for complete details.

REFERRING PHYSICIAN

Physician Name (print): _____

Address: _____

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

Genetic Counselor/Lab Contact Name: _____

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

_____ Date: _____ / _____ / _____
Referring Physician Signature (REQUIRED) *(month)* *(day)* *(year)*

☐ Patient signed completed ABN for genetic testing

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.

Patient Name: _____ Date of Birth: _____ (month) / _____ (day) / _____ (year)

CLINICAL AND LABORATORY INFORMATION (If Available)

Is the patient receiving plasma infusion or plasmapheresis?: ☐ Yes ☐ No

If yes, date: _____

Proband	Family	
☐	☐	Renal disease
☐	☐	Macular degeneration
☐	☐	Other: _____

Creatinine: _____

C3: _____ C4: _____

Has the patient had a kidney biopsy (Y/N)?_____

If so, what was the diagnosis? _____

SAMPLE/SPECIMEN INFORMATION

Collection Date: _____

Time: _____

Has patient received a bone marrow transplant? ☐ Yes ☐ No

If yes, date of bone marrow transplant _____

Percent engraftment _____

Please send saliva kit and two cytobrushes.
Note: STR analysis at an additional charge is required on cytobrushes and saliva samples obtained on all patients post BMT.

TEST(S) REQUESTED

Please see page 3 of requisition for sample requirements.

QUANTITATIVE COMPLEMENT TESTING

☐ **Complete Complement Profile**
(Includes C1q, C2, C3, C4, C5, C6, C7, C8, C9, Factor B, Factor I, Factor H, Factor D (coming soon), Properdin, C1 Inhibitor, and C4 Binding Protein)

☐ C1q	☐ C7	☐ Factor H
☐ C2	☐ C8	☐ Factor D (coming soon)
☐ C3	☐ C9	☐ Properdin
☐ C4	☐ Factor B	☐ C1 Inhibitor
☐ C5	☐ Factor I	☐ C4 Binding Protein
☐ C6		

AUTOANTIBODY TESTING

☐ Factor H Autoantibody

☐ C3 Nephritic Factor

FUNCTION/ACTIVATION TESTING

☐ C5 Functional	☐ C5a
☐ Bb	☐ sC5b-9 (sMAC)
☐ C3a	

ANTI-C5 PHARMACOKINETIC PANEL

☐ **Anti-C5 Pharmacokinetic Panel**
(Includes anti-C5 (Eculizumab) level, C5, C5 functional, and CH50. For assessing complement activity to monitor patients on C5 inhibitor therapy.)

☐ Eculizumab Level	☐ C5
☐ CH50	☐ C5 Functional

GENETIC TESTING

☐ **Dense Deposit Disease/C3 Glomerulonephritis Sequencing Panel**
(Includes *CFH, C3, CFB, CFHR5, CFI,* and *MCP*)
***CCHMC Genetics staff — see below for additional details**

☐ Reflex to deletion/duplication of *C3, CFB*, and *CFI*

☐ Reflex to deletion/duplication of single gene(s)[1] (specify): _____

_____

[1]Deletion/Duplication analysis of CFH, CFHR5, or MCP is not available at this time.

☐ *CFH* Custom Gene Sequencing

☐ *C3* Custom Gene Sequencing
- ☐ Reflex to deletion/duplication of *C3*

☐ *CFB* Custom Gene Sequencing
- ☐ Reflex to deletion/duplication of *CFB*

☐ *CFHR5* Custom Gene Sequencing

☐ *CFI* Custom Gene Sequencing
- ☐ Reflex to deletion/duplication of *CFI*

☐ MCP Custom Gene Sequencing

☐ Targeted (family specific) mutation analysis

Gene of interest _____

Proband's name _____

Proband's DOB _____

Proband's mutation _____

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

SHIPPING

Ship FedEx first overnight

Ship all samples frozen on dry ice to:
CCHMC Division of Nephrology
Clinical Laboratory, T.6-325 Dock 1
240 Albert Sabin Way, Cincinnati, OH 45229
MONDAY—FRIDAY DELIVERY ONLY**

Holiday and Weekend Shipping:
CCHMC Division of Nephrology
3333 Burnet Avenue, Main Dock
Attn: Storeroom BL1.300
Cincinnati, OH 45229

*Dense Deposit Disease/C3 Glomerulonephritis Sequencing Panel should be accessioned with the aHUS Genetic Susceptibility Panel

Patient Name: _____ Date of Birth: _____ / _____ / _____
(month) (day) (year)

DENSE DEPOSIT DISEASE AND C3 GLOMERULOPATHY TESTING INFORMATION SHEET

Test Name	Performing Lab	Specimen Requirements	TAT/ Days Performed	CPT Codes
Quantitative Testing				
Complete Complement Profile	Nephrology 513-636-4530	1 mL red top serum—spun, separated, frozen within 2 hrs of collection; ship on dry ice	1 week	86160 x15
Single complement component (C1q, C2, C3, C4, C5, C6, C7, C8, C9, Factor H, Factor I, Factor B, Factor D, C1 Inhibitor, C4 Binding Protein, Properdin)	Nephrology 513-636-4530	0.5 mL red top serum—spun, separated, frozen within 2 hrs of collection; ship on dry ice	1 week	86160
Autoantibody Testing				
Factor H Autoantibody	Nephrology 513-636-4530	0.5 mL red top serum—spun, separated, frozen within 2 hrs of collection; ship on dry ice	2–4 days Tues, Fri	83516
C3 Nephritic Factor	Nephrology 513-636-4530	1 mL red top serum—spun, separated, frozen within 2 hrs of collection; ship on dry ice	1–2 weeks	86160 x4
Function/Activation Testing				
C5 Functional	Nephrology 513-636-4530	0.5 mL red top serum—spun, separated, frozen within 2 hrs of collection; ship on dry ice	24 hrs Mon—Fri	86161
Bb	Nephrology 513-636-4530	0.5 mL EDTA plasma—spun, separated, frozen within 2 hrs of collection; ship on dry ice	1 week	86160
C3a	Cancer and Blood Disease Institute 513-803-3503	0.5 mL EDTA plasma—spun, separated, frozen within 2 hrs of collection, separate aliquot each test; ship on dry ice	2 weeks	86160
C5a	Cancer and Blood Disease Institute 513-803-3503	0.5 mL EDTA plasma—spun, separated, frozen within 2 hrs of collection, separate aliquot each test; ship on dry ice	2 weeks	86160
sC5b-9 (sMAC)	Cancer and Blood Disease Institute 513-803-3503	0.5 mL EDTA plasma—spun, separated, frozen within 2 hrs of collection, separate aliquot each test; ship on dry ice	1 week	86160
Anti-C5 Therapeutic Monitoring				
Anti-C5 Pharmacokinetic Panel (Includes Anti-C5 (Eculizumab) level, C5, C5 Functional, and CH50)	Nephrology 513-636-4530	1 mL red top serum—spun, separated in two 0.5 mL aliquots, frozen within 2 hrs of collection; ship on dry ice	2–4 days Mon—Fri	80299, 86161, 86162, 86160
Anti-C5 (Eculizumab) Level	Nephrology 513-636-4530	0.5 mL red top serum—spun, separated, frozen within 2 hrs of collection; ship on dry ice	2–4 days Mon—Fri	80299
C5 Functional	Nephrology 513-636-4530	0.5 mL red top serum—spun, separated, frozen within 2 hrs of collection; ship on dry ice	24 hrs Mon—Fri	86161
CH50	Nephrology 513-636-4530	0.5 mL red top serum—spun, separated, frozen within 2 hrs of collection; ship on dry ice	1–4 days Mon—Fri	86162
Genetic Testing				
Dense Deposit Disease/C3 Glomerulonephritis Sequencing Panel (*CFH, C3, CFB, CFHR5, CFI, and MCP*)	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature*	42 days	81479 x10
C3 Custom Gene Sequencing	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature*	90 days	81479
CFH Custom Gene Sequencing	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature*	90 days	81479
CFB Custom Gene Sequencing	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature*	90 days	81479
CFHR5 Custom Gene Sequencing	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature*	90 days	81479
CFI Custom Gene Sequencing	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature*	90 days	81479
MCP Custom Gene Sequencing	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature*	90 days	81479
Deletion/duplication analysis of *C3*, *CFB*, and/or *CFI*	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature* for each gene tested	90 days	81479 for each gene tested
Any single gene sequencing test	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature*	90 days	81479
Targeted mutation analysis	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature*	2 weeks	86160 x4

DO NOT FREEZE SAMPLES FOR GENETIC TESTING.

*Call for other acceptable specimen types.

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