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GENETICS AND GENOMICS DIAGNOSTIC LABORATORY
For local courier service and/or inquiries, please contact 513-636-4474 • Fax: 513-636-4373
www.cincinnatichildrens.org/moleculargenetics • Email: moleculargenetics@cchmc.org

Mailing Address:
3333 Burnet Avenue, Room R1042
Cincinnati, OH 45229

Cincinnati's Undiagnosed and Rare Liver Disease (CURL) Panel Test Requisition

PATIENT INFORMATION

Patient Name: _____ , _____ ,_____
Last First MI

MR# _____ Date of Birth _____ / _____ /_____

Gender: ☐ Male ☐ Female

SPECIMEN REQUIREMENTS

- **3mL Blood in EDTA lavender top tube**

Phlebotomist must initial tube of specimen to confirm sample identity

Please collect samples from all documented family members

ETHNIC/RACIAL BACKGROUND (Choose All That Apply)

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

BILLING INFORMATION

Institution: _____ Accounts Payable Contact Name: _____

Address: _____ Phone: _____

City/State/Zip: _____ Email: _____

Fax: _____

ORDERING PROVIDER INFORMATION

Ordering Provider Name (print):_____ Phone: (_____) _____ Fax: (_____) _____

Email: _____

Primary Clinical Contact Name (if different from ordering provider): _____ Direct Phone: (_____) _____

Email: _____

Acknowledgment of Pre-Test Communication and Incidental Findings Disclosure

I confirm that I have discussed with the patient (or parents/legal guardian) the scope and limitations of this genetic test, including the possibility of identifying incidental findings unrelated to the primary indication for testing. I have informed the patient of the potential clinical significance of such findings and reviewed their preferences regarding receipt of this information (see preferences below).

I informed the family that parental samples are used solely to aid the interpretation of results for diagnosis of the patient (Duo or Trio analysis). No clinical recommendations will be provided for parents based on this testing. I acknowledge my responsibility to disclose relevant findings to the patient and family and facilitate appropriate follow-up, including referral to genetic counseling (www.nsgc.org) or specialty care as needed.

☐ Patient wishes to receive **incidental findings** (unexpected findings found by chance, e.g., cancer risk genes).
☐ Patient does **NOT** wish to receive **incidental findings.**

Ordering Provider Signature (REQUIRED): _____ **Date:** _____ / _____ / _____

SPECIMEN AND FAMILY MEMBER DETAILS

Proband: Specimen Type: ☐ Blood
Specimen Date: _____ / _____ / _____ Time: _____
Specimen Amount: _____
DRAWN BY: _____

Mother: Name: _____
Date of Birth: _____ / _____ /_____
Specimen Type: ☐ Blood
Specimen Date: _____ / _____ / _____ Time: _____
Specimen Amount: _____
DRAWN BY: _____

Father: Name: _____
Date of Birth: _____ / _____ /_____
Specimen Type: ☐ Blood
Specimen Date: _____ / _____ / _____ Time: _____
Specimen Amount: _____
DRAWN BY: _____

Other Family Member: Name:_____
Date of Birth: _____ / _____ /_____
Specimen Type: ☐ Blood
Specimen Date: _____ / _____ / _____ Time: _____
Specimen Amount: _____
DRAWN BY: _____

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Patient Name: _____ , _____ , _____ Date of Birth _____ / _____ / _____
Last First MI

TEST REQUESTED

☐ **Cincinnati's Undiagnosed and Rare Liver Disease (CURL) Panel**

☐ Family Trio (proband and two family members)

☐ Family Duo (proband and one family member)

☐ Proband only

☐ Additional family member; please provide the proband's full name and birthdate:

Proband's full name: _____

Birthdate: _____ / _____ / _____

*Research based whole genome sequencing is available. Do you permit a CCHMC research team to contact you and the patient for future research projects? ☐ Yes ☐ No

CLINICAL HISTORY (REQUIRED)

The patient's clinical phenotypes directly impact results interpretation for this genetic test. It is CRITICAL to provide the clinical information below:

- Patient's working diagnosis: _____
- Cholestasis longer than 3 months: ☐ Yes ☐ No
- History of acute liver failure: ☐ Yes ☐ No
- History of developmental delay needing intervention: ☐ Yes ☐ No
- History of liver transplant: ☐ Yes ☐ No
- Diagnosis of immunodeficiency: ☐ Yes (List:_____ _____) ☐ No
- Congenital anomalies: ☐ Yes (List:_____ _____) ☐ No
- Dysmorphic features: ☐ Yes (List:_____ _____) ☐ No

CLINICAL HISTORY, CONTINUED

Please check all that apply and specify in the space provided. If family member is similarly affected, please indicate relation to proband.

Prenatal/Perinatal History

Proband	Family	
☐	☐	Intrauterine growth retardation _____
☐	☐	Prematurity/postmaturity _____
☐	☐	Poly/oligohydramnios _____
☐	☐	Maternal complications of pregnancy _____
☐	☐	Other _____

General History

Proband	Family	
☐	☐	Failure to thrive _____
☐	☐	Obesity/overgrowth/tall stature _____
☐	☐	Postnatal growth retardation/short stature _____
☐	☐	Developmental delay _____
		☐ Gross motor ☐ Fine motor ☐ Speech
☐	☐	Intellectual disability _____
☐	☐	Developmental regression _____
☐	☐	Autism/autism spectrum disorder _____
☐	☐	Psychiatric disorder _____
☐	☐	Behavioral disorder _____
☐	☐	Cancer Age of onset _____ Type _____
☐	☐	Sudden infant death / Sudden unexplained death
☐	☐	Other _____

Review of Systems

Cardiovascular findings

Proband	Family	
☐	☐	Arrhythmia/conduction defect
☐	☐	Cardiomyopathy
☐	☐	Congenital heart defect (specify _____)
☐	☐	Vascular abnormalities
☐	☐	Others: _____

Craniofacial/Ophthalmalogic/Auditory findings

Proband	Family	
☐	☐	Blindness
☐	☐	Cataract
☐	☐	Cleft palate / cleft lip
☐	☐	Coloboma

Craniofacial/Ophthalmalogic/Auditory findings, continued

Proband	Family	
☐	☐	Craniosynostosis
☐	☐	Dysmorphic facial features
☐	☐	External ear malformation
☐	☐	Glaucoma
☐	☐	Hearing loss
☐	☐	Hemangioma
☐	☐	Hemifacial microsomia
☐	☐	Macrocephaly
☐	☐	Microcephaly
☐	☐	Retinal disorder
☐	☐	Vascular malformation
☐	☐	Others: _____

Dermatologic findings

Proband	Family	
☐	☐	Alopecia
☐	☐	Angiokeratoma
☐	☐	Blistering of skin or mucosa
☐	☐	Cafe au lait spots
☐	☐	Hypopigmentation/ hyperpigmentation
☐	☐	Nail dysplasia
☐	☐	Rash/dermatitis/eczema
☐	☐	Others: _____

Endocrine disorders

Proband	Family	
☐	☐	Adrenal abnormality
☐	☐	Diabetes type 1
☐	☐	Growth hormone abnormality
☐	☐	Sex hormone abnormality
☐	☐	Thyroid disease
☐	☐	Others: _____

Gastrointestinal findings

Proband	Family	
☐	☐	Abnormal liver function
☐	☐	Achalasia
☐	☐	Acute liver failure
☐	☐	Bile duct proliferation
☐	☐	Biliary atresia
☐	☐	Cirrhosis
☐	☐	Chronic constipation
☐	☐	Chronic diarrhea
☐	☐	Congenital anomaly (specify _____)
☐	☐	Hepatomegaly
☐	☐	Jaundice
☐	☐	Liver cysts
☐	☐	Others: _____

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CLINICAL HISTORY, CONTINUED

Hematologic findings

Proband	Family	
☐	☐	Anemia
☐	☐	Bone marrow failure
☐	☐	Excessive bruising
☐	☐	Hematomas
☐	☐	Leukemia/lymphoma
☐	☐	Leukopenia/neutropenia
☐	☐	Splenomegaly
☐	☐	Thrombosis
☐	☐	Thrombocytopenia/small platelets
☐	☐	Others: _____

Immunologic/allergic findings

Proband	Family	
☐	☐	Allergies (specify _____)
☐	☐	Autoimmune disorders
☐	☐	Diffuse inflammation
☐	☐	Enlarged lymph nodes
☐	☐	Fevers
☐	☐	Recurrent, unusual or difficult to treat infections ☐ viral ☐ bacterial ☐ fungal
☐	☐	Small lymph nodes and/or tonsils
☐	☐	Thymic hypoplasia

Neuromuscular findings

Proband	Family	
☐	☐	Abnormal movements
☐	☐	Ataxia
☐	☐	Exercise intolerance/fatigue
☐	☐	Headaches/migraines
☐	☐	Hypertonia
☐	☐	Hypotonia
☐	☐	Neuropathy
☐	☐	Seizure / epilepsy
☐	☐	Stroke/stroke like episodes
☐	☐	Torticollis
☐	☐	Others: _____

Skeletal findings

Proband	Family	
☐	☐	Arachnodactyly
☐	☐	Bone malformation
☐	☐	Clinodactyly
☐	☐	Disproportionate short limbs
☐	☐	Joint contractures
☐	☐	Kyphosis
☐	☐	Polydactyly
☐	☐	Scoliosis
☐	☐	Short stature, proportionate
☐	☐	Short stature, disproportionate
☐	☐	Syndactyly
☐	☐	Vertebral anomaly
☐	☐	Others: _____

ICD-10 Code: _____

Differential Diagnosis: _____

_____

_____

Additional Suspected Genes or Pathways: _____

_____

_____

Additional clinical info: _____

_____

_____

_____

_____

_____

FAMILY HISTORY

Parental consanguinity ☐ Yes ☐ No

Please draw or attach patient's three generation pedigree: