HEART INSTITUTE DIAGNOSTIC LABORATORY-TEST REQUISITION

Patient label	Cincinnati Children's Hospital Medical Center 240 Albert Sabin Way, Room S4.381 Cincinnati, OH 45229-3039 Phone: 513-803-1751 Fax: 513-803-1748

Specimen type: (MM/DD/YYYY)

☐ Blood (3 – 5 ml, purple top tube)
☐ Other _____ Date Collected _____

PATIENT INFORMATION

First Name_____ MI _____ Last Name_____ ☐ M ☐ F ☐ Unknown
DOB _____ Street Address _____
City, State, Zip Code _____

Race:
☐ White
☐ Native American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American

Ethnicity:
☐ Hispanic
☐ Ashkenazi Jewish
☐ Other _____
(check all that apply)

TEST TO BE PERFORMED

☐ DNA extraction

TEST INDICATION

☐ Future clinical testing
☐ Future research testing
☐ Other _____

Estimated storage time _____

REFERRING PHYSICIAN INFORMATION

Physician Name_____ Institution_____

Specialty _____ Phone/Fax_____

Address _____City, State, Zip _____

Email Address _____

Contact Person (i.e. Genetic Counselor)_____Phone _____Fax _____

Required: Authorized Signature_____

HEART INSTITUTE DIAGNOSTIC LABORATORY-PAYMENT INFORMATION

Patient label	Cincinnati Children's Hospital Medical Center 240 Albert Sabin Way, Room S4.381 Cincinnati, OH 45229-3039 Phone: 513-803-1751 Fax: 513-803-1748

PATIENT INFORMATION

First Name_____ MI _____ Last Name_____ ☐ M ☐ F ☐ Unknown

DOB _____ Street Address _____

City, State, Zip Code _____

ONE OF THE TWO FOLLOWING BILLING OPTIONS MUST BE INDICATED.

The Patient Pay option must include payment with sample.

☐ Referring Facility_____

Bill to name_____ and/or Department_____

Facility address_____

Contact name _____ Phone number_____

Institution code _____ Fax number_____

☐ Patient Pay ☐ Credit card ☐ Check

Name (as it appears on credit card)_____ Expiration Date _____

Credit Card Type ☐ Visa ☐ Mastercard ☐ Other _____

Credit Card Number _____ 3 Digit Security Code _____