Cincinnati Children's
changing the outcome together

LABORATORY OF GENETICS AND GENOMICS
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

MITOCHONDRIAL DISORDERS 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 _____ / _____ /_____

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 _____ / _____ / _____

Authorization Number: _____

Insurance ID Number: _____

Insurance Name: _____

Insurance Address: _____

City/State/Zip: _____

Insurance Phone Number: _____

*** PLEASE NOTE:**

- We will not bill Medicaid, Medicaid HMO, or Medicare except for the following: Cincinnati Children's Patients, Cincinnati Children's Providers, or Designated Regional Counties.
- If you have questions, please call 1-866-450-4198 for complete details.

SAMPLE/SPECIMEN INFORMATION

SPECIMEN TYPE: ☐ Amniotic fluid ☐ Blood ☐ Cytobrushes
■ Cord blood ☐ CVS ☐ Bone marrow
☐ Tissue (specify): _____

Specimen Date: _____ / _____ / _____ Time: _____

Specimen Amount: _____

Each test requires 3 mL of whole blood in EDTA tube. Please call before sending alternate tissue samples, and for free cytobrush or saliva collection kits.

DRAWN BY: _____
*Phlebotomist must initial tube of specimen to confirm sample identity

REFERRING PHYSICIAN

Physician Name (print): _____

Address: _____

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

Email: _____

Genetic Counselor/Lab Contact Name: _____

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

Email: _____

_____ Date: ____/ _____/ ____
Referring Physician Signature (REQUIRED)

☐ Patient signed completed ABN

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.

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Patient Name: _____ Date of Birth: _____

INDICATIONS/DIAGNOSIS/ICD-10 CODE

Reason for Testing:

- ☐ Diagnosis in symptomatic patient
- ☐ Carrier (Heterozygote) testing
- ☐ Presymptomatic diagnosis of at-risk sibling
- ☐ Prenatal testing (by previous arrangement only)
- ☐ Other: _____

TEST(S) REQUESTED

Mitochondrial DNA

- ☐ Whole mitochondrial genome (mtDNA) sequencing **and** deletion/duplication analysis by next generation sequencing (NGS)
- ☐ Whole mitochondrial genome (mtDNA) sequencing by NGS
  - ☐ Reflex to deletion/duplication analysis by NGS, if warranted
- ☐ Whole mitochondrial genome (mtDNA) deletion/duplication analysis by NGS for breakpoint analysis
  - ☐ Reflex to mtDNA sequencing by NGS, if warranted
- ☐ Whole mitochondrial genome (mtDNA) deletion/duplication analysis by PCR gel methodology

mtDNA panels

- ☐ Common mutations mtDNA panel (mtDNA 1555, 3243, 3271, 3460, 8344, 8993, 11778, 14459, 14484)
- ☐ Common mutations mtDNA panel with reflex to mtDNA whole genome sequencing
- ☐ Neuromuscular disorders mtDNA panel (MELAS/MERRF: mtDNA 3243, 3271, 8344)
- ☐ Neuromuscular disorders mtDNA panel with reflex to mtDNA whole genome sequencing
- ☐ Leber Hereditary Optic Neuropathy mtDNA panel (mtDNA 3460, 11778, 14459, 14484)
- ☐ Leber Hereditary Optic Neuropathy mtDNA panel with reflex to mtDNA whole genome sequencing
- ☐ Hearing loss mtDNA panel (mtDNA 961, 1555, 1494, 3242, 3271, 7445, 7511, 8344)

POLG-related disorders: AD-PEO, SANDO, MIRAS

- ☐ *POLG* full gene sequencing
  - ☐ Reflex to deletion/duplication of *POLG*

IBMPFD

- ☐ *VCP* full gene sequencing
  - ☐ Reflex to deletion/duplication of *VCP*

- ☐ **Targeted (family specific) mutation analysis of genes listed above**

Gene of interest _____

Proband's name _____

Proband's DOB _____

Proband's mutation _____

Relationship to proband _____

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

If testing was <u>not</u> performed at Cincinnati Children's, please include proband's report and at least 100ng of proband's DNA to use as a positive control.

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Patient Name: _____ Date of Birth: _____

CLINICAL HISTORY

Please describe the patient's symptoms and family history using the checklist below as a guideline. Please attach a pedigree if available: _____

_____

_____

_____

_____

Please describe previously abnormal tests — e.g. Metabolic tests, MRI, Echo, Muscle histology, and functional studies: _____

_____

_____

_____

_____

Proband	Family	
Neurological/Muscular Symptoms		
☐	☐	Seizures or epilepsy
☐	☐	Chronic fatigue syndrome
☐	☐	ALS (Lou Gehrig's disease)
☐	☐	Tremor
☐	☐	Recurrent headaches
☐	☐	Alzheimer's disease
☐	☐	Sensory Neuropathy
☐	☐	Recurrent vomiting
☐	☐	Paget Disease
☐	☐	Cerebral Palsy
☐	☐	Muscle pain
☐	☐	Multiple Sclerosis
☐	☐	Contractures
☐	☐	Muscle weakness
☐	☐	Fibromyalgia
☐	☐	Ataxia
☐	☐	Dysphagia
☐	☐	Muscular Dystrophy
☐	☐	Stroke-like episodes
☐	☐	Muscle wasting
☐	☐	Autoimmune Disease
Developmental Histories		
☐	☐	Autism
☐	☐	Learning Disabilities
☐	☐	Developmental Delay
☐	☐	Mental Retardation
☐	☐	Other: _____

Psychiatric Issues

- ☐ ☐ Anxiety Depression
- ☐ ☐ Bipolar Disorder
- ☐ ☐ OCD
- ☐ ☐ Panic attacks
- ☐ ☐ Schizophrenia
- ☐ ☐ Dementia Memory Loss
- ☐ ☐ Other: _____

Gastrointestinal & Metabolic Disease

- ☐ ☐ Chronic constipation
- ☐ ☐ Recurrent vomiting
- ☐ ☐ Irritable Bowel Syndrome
- ☐ ☐ A known metabolic disorder
- ☐ ☐ Other: _____

Ophthalmologic Problems

- ☐ ☐ CPEO (Opthalmoplegia)
- ☐ ☐ Cataracts Blindness
- ☐ ☐ Ptosis (droopy eyelids)
- ☐ ☐ Retinitis Pigmentosa
- ☐ ☐ Color blindness
- ☐ ☐ Macular degeneration
- ☐ ☐ Visual field defect
- ☐ ☐ Optic atrophy
- ☐ ☐ Corneal deposits
- ☐ ☐ Photophobia

Auditory Problems

- ☐ ☐ Hearing impaired or deaf (please describe):

_____

Cardiac Disease/Symptoms

- ☐ ☐ Chest pains
- ☐ ☐ Shortness of breath
- ☐ ☐ Irregular heart beat
- ☐ ☐ Stroke
- ☐ ☐ Cardiomyopathy
- ☐ ☐ Heart murmur
- ☐ ☐ Other: _____

Other Health Concerns

- ☐ ☐ Diabetes (adult or juvenile)
- ☐ ☐ Kidney Problems
- ☐ ☐ Short stature
- ☐ ☐ Early childhood deaths
- ☐ ☐ SIDS
- ☐ ☐ Skin disorder
- ☐ ☐ Chronic infections
- ☐ ☐ Multiple miscarriages or infertility
- ☐ ☐ Cancer (please describe): _____
- ☐ ☐ Any other condition not listed here (please describe):

_____

_____

_____