

# NEUROVASCULAR DISEASES AND STROKE 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: CCHMC Patients, CCHMC Providers, or Designated Regional Counties.
- If you have questions, please call 1-866-450-4198 for complete details.

## SAMPLE/SPECIMEN INFORMATION

**SPECIMEN TYPE:**  Blood  Saliva  DNA\*

Specimen Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_

Specimen Amount: \_\_\_\_\_

**DRAWN BY:** \_\_\_\_\_

Phlebotomist must initial tube of specimen to confirm sample identity.

Test(s) require 3 mL of whole blood in EDTA, saliva collection kit or 10 mcg of high quality DNA. Only DNA that was extracted in a **CLIA certified lab** can be accepted.  
Contact the lab at 513-636-4474 to obtain a saliva collection kit.

## 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 Genetics and Genomics Diagnostic Laboratory 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.

### INDICATIONS/DIAGNOSIS/ICD-10 CODE

**Select all that apply:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Brain structural vascular abnormalities | <input type="checkbox"/> Carotid or Vertebral artery aneurysm                               | <input type="checkbox"/> Intracranial aneurysm  |
| <input type="checkbox"/> Arterial tortuosity syndrome            | <input type="checkbox"/> Cerebral arteriopathies: aneurysm, stenosis, dissection, vasospasm | <input type="checkbox"/> Intracranial hemorrhage (spontaneous, non-traumatic)                                 |
| <input type="checkbox"/> Cerebral cavernous malformation         | <input type="checkbox"/> Cerebral Venous thrombosis   | <input type="checkbox"/> Moyamoya   |
| <input type="checkbox"/> Arteriovenous malformation              | <input type="checkbox"/> Childhood arterial ischemic stroke                                 | <input type="checkbox"/> Neurocutaneous disorder  |
| <input type="checkbox"/> Arteriovenous fistula                   | <input type="checkbox"/> Familial hemiplegic migraine                                       | <input type="checkbox"/> Pediatric hemorrhagic stroke   |
| <input type="checkbox"/> Cerebral proliferative angiopathy       | <input type="checkbox"/> Head, neck and spine vascular or veno-lymphatic malformation       | <input type="checkbox"/> Family history of stroke or heart disease <50 years old (1st or 2nd degree relative) |
| <input type="checkbox"/> Sinus pericranii                        | <input type="checkbox"/> Hereditary hemorrhagic telangiectasia                              | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Vein of Galen malformation (VGaM)       |   | _____   |

### CLINICAL HISTORY

**PROVIDE AS MANY OF THE FOLLOWING DOCUMENTS AS POSSIBLE TO OPTIMIZE RESULTS INTERPRETATION:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Narrative of clinical presentation and neurologic exam | <input type="checkbox"/> Impression text from MRI/MRA/MRV showing anomaly | <input type="checkbox"/> Impression text from catheter angiography |
| <input type="checkbox"/> Describe any cutaneous vascular markings               | <input type="checkbox"/> Impression text from CT/CTA showing anomaly      | <input type="checkbox"/> Other related investigations/studies      |

### TEST(S) REQUESTED

**Neurovascular Diseases and Stroke Gene Panel (80 genes)**

*ABCC6, ACTA2, ACVRL1, ADA2 (CECR1), ATP1A2, ATP7A, ATR, BRAF, CACNA1A, CBS, CCM2, CENPJ, CEP152, CEP63, CHD4, CLDN14, CNOT3, COL3A1, COL4A1, COL4A2, COLGALT1, EFN2, ENG, EPHA4, EPHB4, FBN1, G6PC, GDF2, GLA, GUCY1A3, HBB, HRAS, HTRA1, JAG1, KRAS, KRIT1, MAP2K1, MYH11, MYLK, NF1, NHLRC2, NIN, NOTCH2, NOTCH3, NRAS, OTC, P2RY1, P2RY12, PCNT, PDCD10, PMM2, POLG, PRRT2, PTPN11, RAF1, RASA1, RBBP8, RNF213, SAMHD1, SCN1A, SCN5A, SETD5, SLC19A2, SLC2A10, SMAD2, SMAD3, SMAD4, SMARCA1, SOS1, SUOX, TGFB2, TGFB3, TGFB1, TGFB2, TREX1, TSC1, TSC2, TTC19, WFS1, YYIAP1*

**Reflex to Whole Exome Sequencing\***

\* Whole exome sequencing (WES) orders require a signed WES Consent Form and completion of the WES Test Requisition. Also, inclusion of biological parental samples is strongly encouraged to assist with the analysis of WES and to increase test yield. Please visit our website at [www.cincinnatichildrens.org/exome](http://www.cincinnatichildrens.org/exome) to obtain the required documents. WES testing will NOT be started until all forms are completed and received by the lab.

**Targeted (family specific) variant analysis of genes listed above**

Gene of interest: \_\_\_\_\_  
 Proband's name: \_\_\_\_\_  
 Proband's DOB: \_\_\_\_\_  
 Proband's variant: \_\_\_\_\_  
 Relationship to proband: \_\_\_\_\_

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

**If testing was not performed at CCHMC, please include proband's report and at least 100ng of proband's DNA to use as a positive control.**

### CUSTOM GENE SEQUENCING

Gene(s) to be sequenced (specify): \_\_\_\_\_

Only genes with clear published functional relationship to rare diseases are accepted.

Suspected syndrome/condition: \_\_\_\_\_

**Please choose one of the following:**

- Full gene(s) sequencing
- Full gene(s) sequencing with reflex to deletion and duplication analysis, if indicated (**please see list of genes available for del/dup at [www.cincinnatichildrens.org/deldup](http://www.cincinnatichildrens.org/deldup)**)
- Familial mutation analysis

Proband's name: \_\_\_\_\_

Proband's DOB: \_\_\_\_\_

Proband's variant: \_\_\_\_\_

Patient's relation to proband: \_\_\_\_\_

**If testing was not performed at CCHMC, please include proband's report and at least 100ng of proband's DNA to use as a positive control.**

### DELETION AND DUPLICATION ASSAY

Gene(s) to be analyzed (specify): \_\_\_\_\_

**Please see list of available genes at: [www.cincinnatichildrens.org/deldup](http://www.cincinnatichildrens.org/deldup)**

Suspected syndrome/condition: \_\_\_\_\_

**Please choose one of the following:**

- Deletion and duplication analysis of gene(s) specified above
- Deletion and duplication analysis of gene(s) specified above with reflex to sequencing, if indicated
- Analysis of gene(s) specified above from previously analyzed deletion and duplication
- Familial deletion analysis

Proband's name: \_\_\_\_\_

Proband's DOB: \_\_\_\_\_

Proband's variant: \_\_\_\_\_

Patient's relation to proband: \_\_\_\_\_

**If testing was not performed at CCHMC, please include proband's report and at least 100ng of proband's DNA to use as a positive control.**