HEART INSTITUTE DIAGNOSTIC LABORATORY- CARDIOMYOPATHY 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 ☐ DNA ☐ 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)

GENE TEST TO BE PERFORMED

☐ Comprehensive Cardiomyopathy Panel
(37 genes) ABCC9, ACTC1, ACTN2, ANKRD1, BAG3, CAV3, CRYAB, CSRP3, DES, EMD, LAMP2, LMNA, MYBPC3, MYH6, MYH7, MYL2, MYL3, MYPN, NEBL, NEXN, PLN, PRKAG2, RBM20, SCN5A, SCO2, SGCD, SURF1, TAZ, TCAP, TNNC1, TNNI3, TNNT2, TPM1, TTN, TTR, VCL, ZASP/LDB3

☐ Hypertrophic Cardiomyopathy Panel
(23 genes) ACTC1, ACTN2, ANKRD1, CAV3, CSRP3, LAMP2, MYBPC3, MYH6, MYH7, MYL2, MYL3, NEXN, PLN, PRKAG2, SCO2, SURF1, TNNC1, TNNI3, TNNT2, TPM1, TTR, VCL, ZASP/LDB3

☐ Dilated Cardiomyopathy Panel
(30 genes) ABCC9, ACTC1, ACTN2, ANKRD1, BAG3, CRYAB, CSRP3, DES, EMD, LAMP2, LMNA, MYBPC3, MYH6, MYH7, MYPN, NEBL, NEXN, PLN, RBM20, SCN5A, SGCD, TAZ, TCAP, TNNC1, TNNI3, TNNT2, TPM1, TTN, VCL, ZASP/LDB3

☐ Left Ventricular Noncompaction
(13 genes) ACTC1, ACTN2, DES, LMNA, MYBPC3, MYH7, MYL2, MYL3, TAZ, TNNT2, TPM1, VCL, ZASP/LDB3

☐ Restrictive Cardiomyopathy
(9 genes) ACTC1, BAG3, CRYAB, DES, MYBPC3, MYH7, TNNI3, TNNT2, TTR

☐ Titin Sequencing

☐ Reflex to Comprehensive Cardiomyopathy Analysis if targeted disease testing is normal

☐ DCM & DMD Related Cardiomyopathy Panel*
(31 genes) ABCC9, ACTC1, ACTN2, ANKRD1, BAG3, CRYAB, CSRP3, DES, DMD, EMD, LAMP2, LMNA, MYBPC3, MYH6, MYH7, MYPN, NEBL, NEXN, PLN, RBM20, SCN5A, SGCD, TAZ, TCAP, TNNC1, TNNI3, TNNT2, TPM1, TTN, VCL, ZASP/LDB3 *Sequencing and Del/Dup Analysis

☐ Known Familial Mutation Test
Gene_____
Mutation_____
Name of Proband_____
Relationship to Proband_____
Please provide copy of report if testing done at another laboratory.

CLINICAL INFORMATION

Clinical Features – Cardiomyopathy (check all that apply)

- ☐ Devices/surgeries
  - ☐ ICD
  - ☐ Pacemaker
  - ☐ Transplant
- ☐ Skeletal muscle involvement
- ☐ Learning difficulties
- ☐ Cardiac findings
  - ☐ Left ventricular hypertrophy
    - ☐ Asymmetric septal hypertrophy
    - ☐ Concentric hypertrophy
  - ☐ Ventricular enlargement/dilation
  - ☐ Ventricular enlargement/dilation
  - ☐ Left ventricular non-compaction
  - ☐ Reduced ejection fraction/endocardial shortening fraction
  - ☐ Atrial enlargement

Clinical diagnosis:

- ☐ Cardiomyopathy
  - ☐ HCM
  - ☐ DCM
  - ☐ RCM
  - ☐ LVNC
  - ☐ Danon disease
  - ☐ Barth syndrome
  - ☐ Leigh syndrome

  Age at diagnosis_____
- ☐ Conduction system disease
  - ☐ WPW
  - ☐ AV block _____
  - ☐ Other _____
- ☐ Other systemic involvement

HEART INSTITUTE DIAGNOSTIC LABORATORY-TEST REQUISITION

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Family History ☐ Family History ☐ No Family History ☐ Patient adopted

List affected family members _____

Pedigree:

Paternal ethnicity:_____

Maternal ethnicity:_____

Consanguinity ☐ Yes ☐ No

TEST INDICATION

☐ Positive Family History ☐ Suspected Diagnosis

☐ Other_____

REFERRING PHYSICIAN INFORMATION

Physician Name_____ Institution_____

Specialty _____ Phone/Fax_____

Address _____City, State, Zip _____

Email Address _____

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

Fax duplicate reports to_____

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 FOLLOWING BILLING OPTIONS MUST BE INDICATED.

The Patient Pay option must include payment with the sample.
The Direct Insurance Billing option must include a copy of the insurance card with the requisition.

☐ **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 _____

☐ **Insurance Company***_____

Subscriber ID: _____ Group Name/Number:_____

Subscriber Name, Address and Phone number: _____

_____

Ordering Physician Name and NPI #: _____

Diagnosis Code(s):_____

*Please note, Cincinnati Children's Hospital Medical Center cannot bill out of state Medicaid.