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: LabGeneticCounselors@cchmc.org

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

HERITABLE PANCREATIC DISEASE TESTING 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 ☐ Saliva
☐ 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-9 CODE

Reason for Testing:

- ☐ Chronic pancreatitis
- ☐ Acute recurrent pancreatitis
- ☐ Acute pancreatitis with family history
- ☐ Pancreatic insufficiency
- ☐ Other: _____

_____

_____

_____

CLINICAL HISTORY

- ☐ Chronic pancreatitis
- ☐ Acute pancreatitis
- ☐ Diabetes
- ☐ Other: _____

_____

_____

_____

TEST(S) REQUESTED

Pancreas Panels by Next-Generation Sequencing (NGS)

☐ **Pancreas Panel**

(CASR, CEL, CFTR, CLDN2, CPA1, CTRC, PRSS1, SBDS, SPINK1, UBR1)

- ☐ Reflex to deletion/duplication of *CASR, CFTR, CPA1, CTRC, PRSS1, SBDS, SPINK1 and UBR1*
- ☐ Reflex to deletion/duplication of single gene(s)[1] (specify): _____

_____

☐ **Pancreatic Insufficiency Panel**

(CEL, CFTR, SBDS, UBR1)

- ☐ Reflex to deletion/duplication of *CFTR, SBDS and UBR1*

Deletion/Duplication analysis of *CEL* or *CLDN2* is not available at this time.

Single Gene Testing*

☐ SBDS full sequence analysis

*Please see the Custom Gene Sequencing section for single gene sequencing of all other Pancreas Panel genes

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

Gene of interest: _____

Proband's name: _____

Proband's DOB: _____

Proband's variant: _____

Patient's relation to proband: _____

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

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)**
- ☐ Familial variant analysis
  - Proband's name: _____
  - Proband's DOB: _____
  - Proband's variant: _____
  - Patient's relation to proband: _____

Please include proband's report, if not performed at CCHMC.

Whole Exome Sequencing
If you are interested in Whole Exome Sequencing, test requisitions are available at: www.cincinnatichildrens.org/exome