



DIVISION OF HUMAN GENETICS
DIAGNOSTIC LABORATORIES

For courier service and/or inquiries, please contact 513-636-4474 • Fax: 513-636-4373
3333 Burnet Avenue, Room R1042, Cincinnati, OH 45229
www.cincinnatichildrens.org/cytogenetics • Email: cytogenetics@cchmc.org
For Saturday delivery, please include "Dock 5" on the airbill

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Director of the Cytogenetics Lab
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Director of the Molecular Genetics Lab

CUSTOM GENE SEQUENCING OR DELETION/DUPLICATION ASSAY 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: Amniotic fluid Blood Bone marrow
Cord blood CVS Cytobrushes DNA Saliva
Tissue (specify):
Specimen Date: / / Time:
Specimen Amount:

Please call before sending tissue samples.

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

Tests require at least 3mL whole blood in EDTA. Multiple genes require at least 5 mL whole blood in EDTA.

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.

**INDICATIONS/DIAGNOSIS/ICD-9 CODE**

Reason for Testing:

- Mutation detection in suspected affected patient
- Carrier testing
- Pre-symptomatic diagnosis of at-risk relative
- Prenatal testing (by previous arrangement only)

Please call 513-636-4474 to discuss any prenatal testing with a genetic counselor prior to shipment.

**PEDIGREE OR FAMILY HISTORY**

 Parental Consanguinity  Y  N

**TEST(S) REQUESTED**
**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 mutation: \_\_\_\_\_

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

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

**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 mutation: \_\_\_\_\_

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

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

**CLINICAL HISTORY**

Symptoms: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Laboratory tests and results: \_\_\_\_\_

\_\_\_\_\_

Previous genetic tests and results: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medical procedures: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medical imaging tests and results: \_\_\_\_\_

\_\_\_\_\_

Other non-genetic diagnostics tests and results: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_