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

PEDIATRIC/ADULT REQUISITION

All Information Must Be Completed Before Sample Can Be Processed

PATIENT INFORMATION

Patient Name: _____ (Last) , _____ (First) , _____ (MI)

MR#: _____

Date of Birth: _____ / _____ / _____ Gender: ☐ M ☐ F

SAMPLE/SPECIMEN INFORMATION

SPECIMEN TYPE: ☐ Peripheral blood ☐ Skin biopsy (site): _____

☐ Other: _____

Specimen Date: _____ / _____ / _____ Time: _____

Specimen Amount: _____

DRAWN BY: _____

LABORATORY TESTS ORDERED

Cytogenetic Testing

- ☐ Routine chromosome analysis*
- ☐ High resolution chromosome analysis*

**For chromosome analysis:* *reflex STAT (2–3 day) prelim results on infants <1 month. Reflex to mosaicism study when sex chromosome/mosaic aneuploidy abnormality suspected by laboratory based on indications provided.*

- ☐ **Reflex**† SNP Microarray if chromosome results are normal
- ☐ SNP Microarray – Constitutional
- ☐ Chromosome mosaicism study
- ☐ Fanconi Anemia (FA) Chromosome Breakage study
- ☐ Bloom syndrome – Sister Chromatid Exchange (SCE) analysis
- ☐ 22q11.2 del (VCFS) (metaphase FISH)
- ☐ SRY (Xp11.1q11.1/Yp11.2) (metaphase FISH)
- ☐ X/Y centromeres (Xp11.1q1.1/Yp11.1q11.1) (interphase FISH)
- ☐ Other FISH (please call laboratory):_____

Molecular Genetic Testing (for full Molecular Genetics test menu, see website)

- ☐ *PTEN* Autism Spectrum Disorder sequencing
- ☐ Fragile X DNA testing
- ☐ *MECP2* sequence analysis (Rett syndrome)
- ☐ *MECP2* deletion/duplication analysis by MLPA
- ☐ Prader-Willi/Angelman – by methylation-sensitive MLPA
- ☐ Spinal Muscular Atrophy – SMN1/SMN2 Copy Number Analysis by MLPA

Neurodevelopmental Reflex Genetic Test**

Tests will be run sequentially based on your selection below:

- ☐ Patient is macrocephalic: SNP Microarray ➔ Fragile X ➔ *PTEN*
- ☐ Male patient with normal or small head circumference: SNP Microarray ➔ Fragile X
- ☐ Female patient with normal or small head circumference: SNP Microarray ➔ Fragile X ➔ *MECP2*

†Additional charge for reflex testing. If SNP Microarray is denied by insurance, Chromosome Analysis will be performed as the first test in the algorithm.

****See page 2 for additional information**

Other testing- please call

- ☐ Family study (please specify): _____
- ☐ Cell culture, storage & freezing of cells
- ☐ Special study/other: _____

REFERRING PROVIDER

Physician Name (print): _____

Address: _____

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

Email: _____

Genetic Counselor/Lab Contact Name: _____

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

Email: _____

_____ Date: _____/ _____/ _____

Referring Provider Signature (REQUIRED)

INDICATIONS/DIAGNOSIS/ICD-10 CODE

Medical/Physical

- ☐ Amenorrhea: 1° or 2°
- ☐ Autism Spectrum Disorder
- ☐ Congenital heart anomaly
- ☐ Dysmorphic features
- ☐ Encephalopathy
- ☐ Failure to thrive
- ☐ Hydrocephalus
- ☐ Hypotonia
- ☐ MRI, abnormal
- ☐ Macrocephaly
- ☐ Microcephaly
- ☐ PDD-NOS
- ☐ Seizures, convulsions
- ☐ Short stature
- ☐ Other: _____

Learning/Behavior

- ☐ Developmental delay/ Intellectual disability
- ☐ ADD/ADHD
- ☐ Language disorder

Family History

- ☐ Family history ID
- ☐ Known chromosome abnormality
- ☐ Fam Hx genetic condition:

_____

_____

- ☐ Consanguinity

(describe relationship):

_____

_____

_____

BILLING INFORMATION

Please call 1-866-450-4198 with questions.

☐ PATIENT BILLING/SELF PAY

Please call 1-866-450-4198 for options

☐ INSTITUTION BILL

Institution: _____

Address: _____

City/State/Zip: _____

Accounts Payable Contact Name: _____

Phone: _____

Fax: _____

Email: _____

☐ COMMERCIAL INSURANCE

Can only be billed if requested at time of service.

☐ Billing information attached — include a copy of insurance card/face sheet

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.

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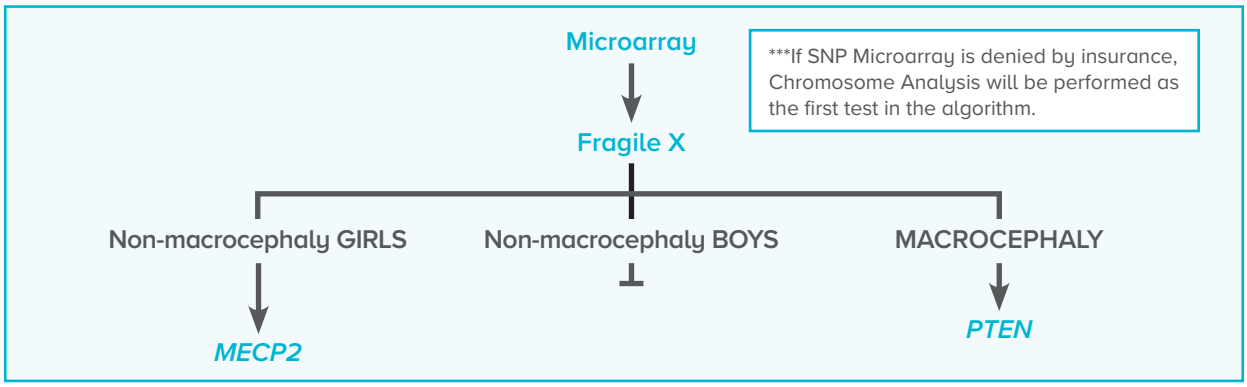
Patient Name: _____ Date of Birth: _____

ADDITIONAL INFORMATION

NEURODEVELOPMENTAL REFLEX GENETIC TESTING ALGORITHM

Tests will be performed sequentially based on the path that your patient follows in the Neurodevelopmental Reflex Test algorithm. Charges will apply to the tests completed in the patient's defined Neurodevelopmental Reflex Test algorithm. Testing will only proceed to the next step if the previous test result is uninformative.



SPECIMEN REQUIREMENTS

Fanconi Anemia Chromosome Breakage Study (please see Fanconi Anemia Requisition for molecular and complementation testing options):
5–10 mLs peripheral blood (NaHep)
5–10 mLs bone marrow (NaHep)
Skin biopsy

Bloom syndrome – Sister Chromatid Exchange (SCE) analysis:
3–5 mL blood (NaHep)

Routine/High Resolution Chromosome analysis:
3–5 mL blood (NaHep)

SNP Microarray:
3 mL blood (NaHep) **and** 3 mL blood (EDTA)

***PTEN* Autism Spectrum Disorder Sequencing:**
3–5 mL blood (EDTA)

Fragile X DNA Testing:
3–5 mL blood (EDTA)

Prader-Willi/Angelman - by MLPA:
3–5 mL blood (EDTA)

FISH Tests:
3–5 mL blood (NaHep)

For any questions about specimen requirements, please call our laboratory at 513-636-4474.

SHIPPING INFORMATION

Shipping:
For samples that arrive **Monday-Friday:**
Cincinnati Children's
Cytogenetic and Molecular Laboratories
3333 Burnet Ave.
TCHRF 1042
Cincinnati, OH 45229-3039

Local courier is available; please call 513-636-4474 for information.

For samples that arrive on **Saturday** (Please call laboratory to inform):
Cincinnati Children's
Cytogenetic and Molecular Laboratories
3333 Burnet Ave.
TCHRF 1042
DOCK 5
Cincinnati, OH 45229-3039

Cancellation Policy: Tests can only be canceled if laboratory is notified prior to the initiation of testing.

☐ Patient signed completed ABN

Medical Necessity Regulations: At the government's request, the 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.