CARDIOVASCULAR DISEASES GENETIC TESTING REQUISITION

Patient label	**Molecular Genetics Laboratory**, Cincinnati Children's 3333 Burnet Avenue, Room NRB 1013 Cincinnati, OH 45229 Phone: 513-636-4474 Fax: 513-636-4373

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:
- ☐ Caucasian
- ☐ 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

- ☐ CASQ2 Sequencing
- ☐ CAV3 Sequencing
- ☐ DES Sequencing
- ☐ EMD Sequencing
- ☐ KCNJ2 Sequencing
- ☐ LAMP2 Sequencing
- ☐ LDB3 Sequencing
- ☐ LMNA Sequencing
- ☐ MYBPC3 Sequencing
- ☐ MYH7 Sequencing
- ☐ MYL2 Sequencing
- ☐ MYL3 Sequencing
- ☐ SCO2 Sequencing
- ☐ SURF1 Sequencing
- ☐ TNNT2 Sequencing

☐ Known Familial Mutation Test

Gene_________________________________

Mutation______________________________

Name of Proband_______________________

Relationship to Proband__________________

Please provide copy of the report if test was performed at another laboratory

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: Physician Signature____

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

List affected family member(s) ____

Pedigree:

Paternal ethnicity:____

Maternal ethnicity:____

Consanguinity ☐ Yes ☐ No

TEST INDICATION

☐ Positive Family History ☐ Suspected Diagnosis

☐ Other____

CARDIOVASCULAR DISEASES GENETIC TESTING - PAYMENT INFORMATION

Patient label	**Molecular Genetics Laboratory**, Cincinnati Children's 3333 Burnet Avenue, Room NRB 1013 Cincinnati, OH 45229 Phone: 513-636-4474 Fax: 513-636-4373

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.