CARDIOVASCULAR DISEASES GENETIC TESTING - ARRHYTHMIA TEST 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:
- ☐ 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

☐ **Atrial Fibrillation Panel** – 16 genes
(ABCC9, GJA5, KCNA5, KCND3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, LMNA, NPPA, NUP155, SCN1B, SCN2B, SCN3B, SCN5A)

☐ **AV Block Panel** – 7 genes
(DES, EMD, LMNA, NKX2.5, SCN1B, SCN5A, TRPM4)

☐ **Brugada Syndrome Panel** – 15 genes
(CACNA1C, CACNA2D1, CACNB2, GPD1L, HCN4, KCND3, KCNE3, KCNJ8, RANGRF, SCN1B, SCN2B, SCN3B, SCN5A, SLMAP, TRPM4)

☐ **CPVT Panel** – 6 genes
(ANK2, CALM1, CASQ2, KCNJ2, RYR2, TRDN)

☐ **Long QT Panel** – 14 genes
(AKAP9, ANK2, CACNA1C, CALM1, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNJ5, KCNQ1, SCN4B, SCN5A, SNTA1)

☐ **Short QT Panel** – 6 genes
(CACNA1C, CACNA2D1, CACNB2, KCNH2, KNCJ2, KCNQ1)

☐ **Cardiac Channelopathy Panel** – 32 genes
(ABCC9, AKAP9, ANK2, CACNA1C, CACNA2D1, CACNB2, CALM1, CASQ2, CAV3, GPD1L, HCN4, KCNA5, KCND3, KCNE1, KCNE2, KCNE3, KCNH2, KCNJ2, KCNJ5, KCNJ8, KCNQ1, RANGRF, RYR2, SCN1B, SCN2B, SCN3B, SCN4B, SCN5A, SLMAP, SNTA1, TRND, TRPM4)

☐ CASQ2 Sequencing

☐ CAV3 Sequencing

☐ KCNJ2 Sequencing

☐ Known Familial Mutation Test
Gene_________________________________
Mutation______________________________
Name of Proband_______________________
Relationship to Proband__________________
Please provide copy of report if testing was done at another laboratory.

TEST INDICATION

☐ Positive Family History ☐ Suspected Diagnosis ________________________________

☐ Other____

CARDIOVASCULAR DISEASES GENETIC TESTING - ARRHYTHMIA TEST 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

CLINICAL INFORMATION

Clinical Features – Arrhythmia (check all that apply)

- ☐ Periodic paralysis
- ☐ Syncope
- ☐ Seizure
- ☐ Palpitations
- ☐ Dysmorphic features
  - ☐ Hypertelorism
  - ☐ Syndactyly
  - ☐ Clinodactyly
  - ☐ Short stature
  - ☐ Scoliosis
- ☐ Learning difficulties
- ☐ Autism
- ☐ Congenital hearing loss

- ☐ Cardiac arrest
- ☐ Sudden death
- ☐ Conduction system disease
  - ☐ WPW
  - ☐ Prolonged QT interval: ______msec
  - ☐ AV block _______
  - ☐ Ventricular arrhythmias
  - ☐ Atrial fibrillation
  - ☐ Short QT interval
  - ☐ Brugada syndrome
  - ☐ CPVT

Additional Features:

- ☐ Cardiomyopathy
  - ☐ HCM
  - ☐ DCM
  - ☐ RCM
  - ☐ LVNC

Other_____________________
____

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

List affected family members ____

Pedigree:

Paternal ethnicity:____

Maternal ethnicity:____

Consanguinity ☐ Yes ☐ No

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____

CARDIOVASCULAR DISEASES GENETIC TESTING PROGRAM - 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.