Comprehensive Cardiomyopathy Panel
(37 genes) ABC9, ACTC1, ACTN2, ANKRD1, BAG3, CAV3, CRYAB, CSRP3, DES, EMD, LAMP2, LMNA, MYBP3, MYH6, MYH7, MYL2, MYL3, MYPN, NEBL, NEXN, PLN, PRKAG2, RRM20, SCN5A, SLO2, SGCD, SURF1, TAZ, TCAP, TNNC1, TNNT2, TPM1, TTN, TTR, VCL, ZASP/LDB3

Hypertrophic Cardiomyopathy Panel
(23 genes) ACTC1, ACTN2, ANKRD1, CAV3, CSRP3, LAMP2, MYBP3, MYH6, MYH7, MYL2, MYL3, NEXN, PLN, PRKAG2, SLO2, SURF1, TNNC1, TNNT2, TPM1, TTN, TTR, VCL, ZASP/LDB3

Dilated Cardiomyopathy Panel
(30 genes) ABC9, ACTC1, ACTN2, ANKRD1, BAG3, CRYAB, CSRP3, DES, EMD, LAMP2, LMNA, MYBP3, MYH6, MYH7, MYL2, MYL3, NEXN, PLN, PRKAG2, SLO2, SURF1, TNNC1, TNNT2, TPM1, TTN, TTR, VCL, ZASP/LDB3

Left Ventricular Noncompaction
(12 genes) ACTC1, ACTN2, DES, LMNA, MYBP3, MYH7, MYL2, MYL3, TAZ, TNNT2, VCL, ZASP/LDB3

Restrictive Cardiomyopathy
(9 genes) ACTC1, BAG3, CRYAB, DES, MYBP3, MYH7, TNNT3, TNNT2, TTR

GENE TEST TO BE PERFORMED

☐ Comprehensive Cardiomyopathy Panel

☐ Hypertrophic Cardiomyopathy Panel

☐ Dilated Cardiomyopathy Panel

☐ Left Ventricular Noncompaction

☐ Restrictive Cardiomyopathy

☐ Known Familial Mutation Test
  Gene______________________
  Mutation__________________
  Name of Proband______________
  Relationship to Proband__________

  Please provide copy of report if testing done at another laboratory.

☐ Titin Sequencing

☐ Reflex to Comprehensive Cardiomyopathy Analysis if targeted disease testing is normal

☐ Devices/surgeries
  ☐ ICD
  ☐ Pacemaker
  ☐ Transplant

☐ Skeletal muscle involvement

☐ Learning difficulties

☐ Cardiac findings
  ☐ Left ventricular hypertrophy
    ☐ Asymmetric septal hypertrophy
    ☐ Concentric hypertrophy
  ☐ Ventricular enlargement/dilation

☐ Ventricular enlargement/dilation

☐ Left ventricular non-compaction

☐ Reduced ejection fraction/endocardial shortening fraction

☐ Atrial enlargement

Clinical Features – Cardiomyopathy (check all that apply)

Clinical Information

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

Patient label

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

Other ____________________ (check all that apply)

CLINICAL INFORMATION
## 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

**Family History**

- [ ] Family History
- [ ] No Family History
- [ ] Patient adopted

List affected family members _______________________________________________________

**Pedigree:**

Paternal ethnicity: ____________________________________________________________

Maternal ethnicity: ____________________________________________________________

Consanguinity [ ] Yes [ ] No

## TEST INDICATION

- [ ] Positive Family History
- [ ] Suspected Diagnosis
- [ ] Other __________________________________________

## 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:** Authorized Signature ____________________________
**CARDIOVASCULAR DISEASES GENETIC TESTING - PAYMENT INFORMATION**

<table>
<thead>
<tr>
<th>Patient label</th>
<th>Molecular Genetics Laboratory, Cincinnati Children’s 3333 Burnet Avenue, Room NRB 1013 Cincinnati, OH 45229 Phone: 513-636-4474 Fax: 513-636-4373</th>
</tr>
</thead>
</table>

**PATIENT INFORMATION**

First Name_________________ MI _______ Last Name______________________ □ M □ F □ Unknown

DOB ____________________ Street Address ______________________________________

City, State, Zip Code __________________________________________________________

**ONE OF THE TWO FOLLOWING BILLING OPTIONS MUST BE INDICATED**

The Patient Pay option must include payment with sample.

- [ ] 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 _____________