CARDIOVASCULAR DISEASES GENETIC TESTING REQUISITION - CARDIOMYOPATHY

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

☐ Comprehensive Cardiomyopathy Panel
(37 genes) ABCC9, ACTC1, ACTN2, ANKRD1, BAG3, CAV3, CRYAB, CSRP3, DES, EMD, LAMP2, LMNA, MYBPC3, MYH6, MYH7, MYL2, MYL3, MYPN, NEBL, NEXN, PLN, PRKAG2, RBM20, SCN5A, SCO2, SGCD, SURF1, TAZ, TCAP, TNNC1, TNNI3, TNNT2, TPM1, TTN, TTR, VCL, ZASP/LDB3

☐ Hypertrophic Cardiomyopathy Panel
(23 genes) ACTC1, ACTN2, ANKRD1, CAV3, CSRP3, LAMP2, MYBPC3, MYH6, MYH7, MYL2, MYL3, NEXN, PLN, PRKAG2, SCO2, SURF1, TNNC1, TNNI3, TNNT2, TPM1, TTR, VCL, ZASP/LDB3

☐ Dilated Cardiomyopathy Panel
(30 genes) ABCC9, ACTC1, ACTN2, ANKRD1, BAG3, CRYAB, CSRP3, DES, EMD, LAMP2, LMNA, MYBPC3, MYH6, MYH7, MYPN, NEBL, NEXN, PLN, RBM20, SCN5A, SGCD, TAZ, TCAP, TNNC1, TNNI3, TNNT2, TPM1, TTN, VCL, ZASP/LDB3

☐ Left Ventricular Noncompaction
(12 genes) ACTC1, ACTN2, DES, LMNA, MYBPC3, MYH7, MYL2, MYL3, TAZ, TNNT2, VCL, ZASP/LDB3

☐ Restrictive Cardiomyopathy
(9 genes) ACTC1, BAG3, CRYAB, DES, MYBPC3, MYH7, TNNI3, TNNT2, TTR

☐ Titin Sequencing

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

☐ Known Familial Mutation Test
Gene_____
Mutation_____
Name of Proband_____
Relationship to Proband_____
Please provide copy of report if testing done at another laboratory.

CLINICAL INFORMATION

Clinical Features – Cardiomyopathy (check all that apply)

- ☐ 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 diagnosis:

- ☐ Cardiomyopathy
  - ☐ HCM
  - ☐ DCM
  - ☐ RCM
  - ☐ LVNC
  - ☐ Danon disease
  - ☐ Barth syndrome
  - ☐ Leigh syndrome

  Age at diagnosis_____
- ☐ Conduction system disease
  - ☐ WPW
  - ☐ AV block _____
  - ☐ Other _____
- ☐ Other systemic involvement

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

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 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 _____