## HEART INSTITUTE DIAGNOSTIC LABORATORY - PRENATAL SAMPLE REQUISITION

(Must be completed in addition to the individual Test Requisition)

| Patient label | Cincinnati Children’s Hospital Medical Center  
|              | 240 Albert Sabin Way, Room S4.381  
|              | Cincinnati, OH 45229-3039  
|              | Phone: 513-803-1751 Fax: 513-803-1748 |

### PATIENT INFORMATION

<table>
<thead>
<tr>
<th>First Name</th>
<th>MI</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
<tr>
<td>DOB</td>
<td>Street Address</td>
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<td></td>
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<tr>
<td>City, State, Zip Code</td>
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</tbody>
</table>

Fetal Specimen type: (MM/DD/YYYY)

- [ ] Amniotic Fluid
- [ ] Chorionic Villi
- [ ] Cultured Cells

Date Collected _________________

Maternal Specimen type: (MM/DD/YYYY)

- [ ] Blood
- [ ] Buccal swab (X2)
- [ ] Other

Date Collected _________________

### SAMPLE REQUIREMENTS

<table>
<thead>
<tr>
<th>AMNIOTIC FLUID</th>
<th>Chorionic Villi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amniotic Fluid – 20mL</td>
<td>Chorionic Villi – 30+mg</td>
</tr>
<tr>
<td>Maternal sample – 3mL blood in EDTA Lavender top tube</td>
<td>Maternal sample – 3mL blood in EDTA Lavender top tube OR 2 buccal swabs</td>
</tr>
<tr>
<td>OR 2 buccal swabs</td>
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</tbody>
</table>

### TEST TO BE PERFORMED

GENE TEST TO BE PERFORMED

(Individual gene test requisition must be included)

Is this a known mutation – Yes / No  If yes, what is the known mutation _________________

- [ ] Amniotic Fluid (Requires cell culture and maternal cell contamination studies)
- [ ] Chorionic Villi (Requires cell culture and maternal cell contamination studies)
- [ ] Cultured cells (Requires maternal cell contamination studies)

Ordering Physician’s signature ____________________________ Date ____________________________

(Required)

Please note:

- Call Amy Shikany, Genetic Counselor for the Heart Institute Diagnostic Lab, at 513-803-3317 before sending prenatal samples
- Turnaround time is estimated to be 4-6 weeks. Prenatal samples are given priority
- The Heart Institute Diagnostic Lab does not accept samples on the weekends or holidays
- If you are sending prenatal cells in culture, make sure that your institution keeps a back up culture
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.