

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:

Ethnicity:

- | | |
|--|---|
| <input type="checkbox"/> White | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> Native American Indian or Alaska Native | <input type="checkbox"/> Ashkenazi Jewish |
| <input type="checkbox"/> Asian | |
| <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Black or African American | (check all that apply) |

GENE TEST TO BE PERFORMED

- LDLR Full Sequencing
- LDLR Known Familial Mutation Test
Mutation _____
Name of Proband _____
Relationship to Proband _____
Please provide a copy of the report if the test was performed at another laboratory
- APOB (R3500Q/R3500W) Sequencing

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 _____

**FAMILIAL HYPERCHOLESTEROLEMIA
DISEASE SPECIFIC REQUISITION FORM**

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TEST INDICATION

- Suspected Diagnosis Positive family history
- Other _____
(check all that apply)

Family History Family History No Family History Patient adopted

List affected family members _____

Pedigree:

Paternal ethnicity: _____

Maternal ethnicity: _____

Consanguinity Yes No

CARDIOVASCULAR DISEASES GENETIC TESTING - PAYMENT INFORMATION

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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.