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:
- ☐ 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

☐ Marfan syndrome and Related Disorders Panel (FBN1, TGFBR1, TGFBR2)

☐ FBN1 Full Gene Sequencing

☐ TGFBR1 Full Gene Sequencing

☐ TGFBR2 Full Gene Sequencing

☐ Known Familial Mutation Test
Gene__________________ Mutation ____

Name of Proband ________________________Relationship to Proband______________________
Please provide copy of report if testing done at another laboratory.

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____

MARFAN SYNDROME AND LOEYS-DIETZ SYNDROME
DISEASE SPECIFIC REQUISITION FORM

Name: ____

DOB: _____ / _____ / _____ (MM/DD/YY)

TEST INDICATION

☐ Cardiac involvement
☐ Cleft palate or bifid uvula
☐ Craniosynostosis
☐ Positive family history
☐ Other____
☐ Ocular involvement
☐ Skeletal involvement
☐ Vascular involvement (arterial aneurysm or tortuosity)

CLINICAL INFORMATION

Clinical Features – Marfan syndrome (check all that apply)

Cardiac:
☐ Aortic dilation (ascending)
Sinotubular junction ___________ cm
☐ Aortic dissection
☐ Ascending thoracic
☐ Descending thoracic
☐ Abdominal
☐ Mitral valve prolapse
☐ Regurgitation
☐ Pulmonary artery dilation
☐ Mitral annulus calcification (age <40)
☐ Other _________________

Dura:
☐ Dural ectasia

Pulmonary:
☐ Spontaneous pneumothorax
☐ Apical blebs

Skin
☐ Striae atrophicae
☐ Recurrent incisional hernia

Skeletal
☐ Pectus carinatum
☐ Pectus excavatum
☐ Surgical repair
☐ Wrist AND thumb sign
☐ Reduced upper:lower segment OR arm span:height >1.05
☐ Scoliosis - degree _______________
☐ Reduced elbow extension
☐ Pes planus
☐ Protrusio acetabuli
☐ Joint hypermobility
Beighton score_______________
☐ High arched palate
☐ Facial findings _________________

Ocular:
☐ Ectopia Lentis
☐ Flat cornea
☐ Increased length of globe
☐ Hypoplastic iris OR ciliary muscle (decreased miosis)

Diagnostic criteria ☐ Clinical diagnostic criteria met ☐ Suggestive features do not meet clinical criteria

Additional Features – Loeys-Dietz syndrome (check all that apply)
☐ Craniosynostosis ☐ Cleft palate OR bifid uvula ☐ Talipes equinovarus ☐ Easy bruising
☐ Vascular findings: including arterial aneurysms and dissection

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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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.