Cardiovascular Diseases Genetic Testing - RASopathy/Noonan Spectrum Panel 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

☐ **RASopathy/Noonan Spectrum Disorders Panel** (25 genes) A2ML1, BRAF, CBL, HRAS, KRAS, LZTR1, MAP2K1, MAP2K2, NF1, NF2, NRAS, PTEN, PTPN11, RAF1, RASA1, RASA2, RIT1, RRAS, SHOC2, SOS1, SOS2, SPRED1, TBCK, TSC1, TSC2
- ☐ Parental blood provided for parental comparative analysis

Prenatal Noonan Spectrum Disorders Panel (12 genes) BRAF, HRAS, KRAS, LZTR1, MAP2K1, MAP2K2, NRAS, PTPN11, RAF1, RIT1, SOS1, SOS2
- ☐ Parental blood provided for parental comparative analysis

☐ **Prenatal Noonan Reflex to RASopathy** (13 genes) A2ML1, CBL, NF1, NF2, PTEN, RASA1, RASA2, RRAS, SHOC2, SPRED1, TBCK, TSC1, TSC2
- ☐ Parental blood provided for parental comparative analysis

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

PARENTAL INFORMATION

First Name_____ MI _____ Last Name_____ ☐ M ☐ F ☐ Unknown
DOB _____

Race:
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- ☐ Native Hawaiian or other Pacific Islander
- ☐ Black or African American

Ethnicity:
- ☐ Hispanic
- ☐ Ashkenazi Jewish
- ☐ Other _____

(check all that apply)

PARENTAL INFORMATION

First Name_____ MI _____ Last Name_____ ☐ M ☐ F ☐ Unknown
DOB _____

Race:
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- ☐ Asian
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Ethnicity:
- ☐ Hispanic
- ☐ Ashkenazi Jewish
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(check all that apply)

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Family History ☐ Family History ☐ No Family History ☐ Patient adopted
List affected family members _____
Pedigree:

Paternal ethnicity: _____
Maternal ethnicity: _____
Consanguinity ☐ Yes ☐ No

TEST INDICATION

- ☐ Congenital heart defect
- ☐ Hypertrophic cardiomyopathy
- ☐ Dysmorphic features
- ☐ Short stature
- ☐ Developmental delay
- ☐ Webbed neck
- ☐ Bleeding diathesis
- ☐ Other_____

CLINICAL INFORMATION

Clinical Features–RASopathy/Noonan syndrome (check all that apply)

- ☐ Dysmorphology
  - ☐ Low-set ears
  - ☐ Ptosis
  - ☐ Pectus
  - ☐ Webbed neck
  - ☐ Hypertelorism
  - ☐ Short stature

Other pertinent features _____
_____
_____

Clinical Diagnosis:

- ☐ Cardiomyopathy
  - ☐ HCM
  - ☐ DCM
  - ☐ LVNC
  - ☐ RCM
- ☐ Conduction system disease
- ☐ Congenital heart disease
  - ☐ ASD
  - ☐ PS
  - ☐ VSD

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 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.