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

☐ Pulmonary Arterial Hypertension Panel
(10 genes) ABCA3, ACVRL1, BMPR2, CAV1, ENG, GDF2, KCNA5, KCNK3, SMAD4, SMAD9

☐ Known Familial Mutation Test

Gene_____ Mutation _____

Name of Proband _____Relationship to Proband_____

Please provide copy of report if testing done at another laboratory.

TEST INDICATION

☐ Suspected diagnosis ☐ Positive family history

☐ Other_____

(check all that apply)

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_____

Pulmonary Atrerial Hypertension Panel REQUISITION FORM

Name: _____

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

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

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.