# CARdiovascular Diseases Genetic Testing - Prenatal Sample Requisition

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

<table>
<thead>
<tr>
<th align="left">Patient label</th>
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<tbody>
<tr>
<td align="left">Molecular Genetics Laboratory, Cincinnati Children’s 3333 Burnet Avenue, Room NRB 1013 Cincinnati, OH 45229 Phone: 513-636-4474 Fax: 513-636-4373</td>
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## Patient Information

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<tr>
<th>First Name</th>
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<th>Last Name</th>
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<th>DOB</th>
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<th>City, State, Zip Code</th>
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### Fetal Specimen type:

- ☐ Amniotic Fluid
- ☐ Chorionic Villi
- ☐ Cultured Cells
- ☐ Other

Date Collected ________________________________________

### Maternal Specimen type:

- ☐ Blood
- ☐ Buccal swab (X2)
- ☐ Other

Date Collected ________________________________________

## Sample Requirements

### Amniotic Fluid

- Amniotic Fluid – 20mL
- Maternal sample – 3mL blood in EDTA Lavender top tube
- OR 2 buccal swabs

### Chorionic Villi

- Chorionic Villi – 30+mg
- Maternal sample – 3mL blood in EDTA Lavender top tube OR 2 buccal swabs

## 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:

- Please call 513-636-4474 to discuss prenatal testing with a genetic counselor prior to shipment
- Turnaround time is for specific test ordered, however prenatal samples are given priority
- If you are sending prenatal cells in culture, make sure that your institution keeps a back-up culture
- For samples that will arrive on Saturday, please call laboratory at 513-636-4474 to inform