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:
- ☐ Caucasian
- ☐ 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

Specific Site Analysis

☐ Single Gene Sequencing

Gene Name: ____________________

Additional Information:

____

____

____

____

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____

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

Family History ☐ Family History ☐ No Family History ☐ Patient adopted

List affected family members ____

Pedigree:

Paternal ethnicity: ____

Maternal ethnicity: ____

Consanguinity ☐ Yes ☐ No

TEST INDICATION

☐ Positive Family History ☐ Suspected Diagnosis

☐ Other____

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.