

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

TAZ/G4.5 Sequencing

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

Cardiomyopathy

Neutropenia

3-methylglutaconic aciduria

Other _____

(check all that apply)

Positive family history

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 _____

**TAZ MUTATION
DISEASE SPECIFIC REQUISITION FORM**

Name: _____

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

**CLINICAL INFORMATION
Barth syndrome - TAZ**

Cardiac:

- Dilated Cardiomyopathy
- Left ventricular noncompaction
- Arrhythmia _____

Additional features:

- Neutropenia
- Decreased total cholesterol
- 3-methylglutaconic aciduria
- Skeletal myopathy
- Growth delay
- Other _____

Additional Features:

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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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.