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

☐ TBX5 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

- ☐ Congenital heart disease
- ☐ Arrhythmia
- ☐ Limb or hand anomaly
- ☐ Other_____
- ☐ Positive family history
- ☐ Situs anomalies (organ reversal or abnormal position)
- ☐ Dysmorphic features

(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_____