

# PLATELET DISORDERS GENE SEQUENCING PANEL REQUISITION

All Information Must Be Completed Before Sample Can Be Processed

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_

MR# \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender:  Male  Female

## ETHNIC/RACIAL BACKGROUND (Choose All)

European American (White)  African-American (Black)

Native American or Alaskan  Asian-American

Pacific Islander  Ashkenazi Jewish ancestry

Latino-Hispanic \_\_\_\_\_  
(specify country/region of origin)

Other \_\_\_\_\_  
(specify country/region of origin)

## BILLING INFORMATION (Choose ONE method of payment)

### REFERRING INSTITUTION

Institution: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Accounts Payable Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

### COMMERCIAL INSURANCE\*

**Insurance can only be billed if requested at the time of service.**

Policy Holder Name: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Authorization Number: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_

Insurance Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_

**\* PLEASE NOTE:**

- We will not bill Medicaid, Medicaid HMO, or Medicare except for the following: CCHMC Patients, CCHMC Providers, or Designated Regional Counties.
- If you have questions, please call 1-866-450-4198 for complete details.

## SAMPLE/SPECIMEN INFORMATION

**SPECIMEN TYPE:**  Blood  Saliva

Specimen Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_

Specimen Amount: \_\_\_\_\_

**DRAWN BY:** \_\_\_\_\_

\*Phlebotomist must initial tube of specimen to confirm sample identity.

Tests require 3 mL of whole blood in EDTA. Multiple genes require at least 5 mL whole blood in EDTA.

**WE ARE UNABLE TO ACCEPT BLOOD SAMPLES COLLECTED WITHIN TWO (2) WEEKS OF A TRANSFUSION.**

## REFERRING PHYSICIAN

Physician Name (print): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Genetic Counselor/Lab Contact Name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Referring Physician Signature (REQUIRED)**

Patient signed completed ABN

Medical Necessity Regulations: At the government's request, the Molecular Genetics Laboratories would like to remind all physicians that when ordering tests that will be paid under federal health care programs, including Medicare and Medicaid programs, that these programs will pay only for those tests the relevant program deems to be (1) included as covered services, (2) reasonable, (3) medically necessary for the treatment and diagnosis of the patient, and (4) not for screening purposes.

### INDICATIONS/DIAGNOSIS/ICD-9 CODE

Reason for Testing:

- Platelet dysfunction/defect
- Abnormal bleeding
- Unexplained Thrombocytopenia
- Easy bruising/spontaneous ecchymoses
- Positive family history of bleeding disorders or platelet function disorders  
Please specify relationship (e.g., cousin): \_\_\_\_\_
- Other: \_\_\_\_\_

### CLINICAL HISTORY

Please include copies of the following documents (if available) for comprehensive analysis:

- CBC with platelet count, mean platelet volume
- Family history of bleeding disorders
- Bleeding assessment tool (type) and score
- von Willebrand testing
- Platelet Function Analysis (PFA) results
- Platelet aggregation testing
- Mean platelet volume (MPV) & platelet distribution width (PDW)

### TEST(S) REQUESTED

#### Platelet Disorders

- Platelet Disorders Gene Sequencing Panel**  
(*ABCG5, ABCG8, ACBD5, ACTN1, ANKRD26, ANO6, AP3B1, AP3D1, ARPC1B, BLOC1S3, BLOC1S6, CD36, CYCS, DIAPH1, DTNBP1, ETV6, FERMT3, FLI1, FLNA, FYB1, GATA1, GFI1B, GP1BA, GP1BB, GP6, GP9, HOXA11, HPS1, HPS3, HPS4, HPS5, HPS6, ITGA2, ITGA2B, ITGB3, LYST, MASTL, MECOM, MPIG6B, MPL, MYH9, NBEA, NBEAL2, ORAI1, P2RX1, P2RY1, P2RY12, PLA2G4A, PRKACG, PTGS1, RAB27A, RASGRP2, RBM8A, RUNX1, SLFN14, STIM1, STX11, STXBP2, TBXA2R, TBXAS1, THPO, TUBB1, UNC13D, VIPAS39, VPS33B, VPS45, WAS*)
- Reflex to deletion/duplication for all available genes\***  
(*ABCG5, ABCG8, ACBD5, ACTN1, ANKRD26, ANO6, AP3B1, AP3D1, ARPC1B, BLOC1S3, BLOC1S6, CD36, CYCS, DIAPH1, DTNBP1, ETV6, FLI1, FLNA, FYB1, GATA1, GFI1B, GP1BA, GP1BB, HOXA11, HPS1, HPS3, HPS4, ITGA2, ITGA2B, ITGB3, LYST, MASTL, MECOM, MPL, MYH9, NBEA, NBEAL2, ORAI1, P2RX1, P2RY12, PLA2G4A, PRKACG, RAB27A, RASGRP2, RBM8A, RUNX1, SLFN14, STIM1, STX11, STXBP2, TBXA2R, TBXAS1, THPO, TUBB1, UNC13D, VIPAS39, VPS33B, VPS45, WAS*)
- Reflex to deletion/duplication of single gene(s) (specify): \_\_\_\_\_

\*Deletion/Duplication analysis of *FERMT3, GP6, GP9, HPS5, HPS6, MPIG6B, P2RY1*, and *PTGS1* is not available at this time.

- Targeted (family specific) mutation analysis of genes listed above**

Gene of interest: \_\_\_\_\_  
 Proband's name: \_\_\_\_\_  
 Proband's DOB: \_\_\_\_\_  
 Proband's variant: \_\_\_\_\_  
 Relationship to proband: \_\_\_\_\_

**Please call 513-636-4474 to discuss any family-specific mutation analysis with genetic counselor prior to shipment.**

**If testing was not performed at CCHMC, please include proband's report and at least 100ng of proband's DNA to use as a positive control.**

#### Whole Exome Sequencing

If you are interested in Whole Exome Sequencing, test requisitions are available at: [www.cincinnatichildrens.org/exome](http://www.cincinnatichildrens.org/exome)

### CUSTOM GENE SEQUENCING

Gene(s) to be sequenced (specify): \_\_\_\_\_  
 \_\_\_\_\_

Only genes with clear published functional relationship to rare diseases are accepted.

Suspected syndrome/ condition: \_\_\_\_\_

Please choose one of the following:

- Full gene(s) sequencing
- Full gene(s) sequencing with reflex to deletion and duplication analysis, if indicated (**please see list of genes available for del/dup at [www.cincinnatichildrens.org/deldup](http://www.cincinnatichildrens.org/deldup)**)

- Familial mutation analysis

Proband's name: \_\_\_\_\_

Proband's DOB: \_\_\_\_\_

Proband's variant: \_\_\_\_\_

Patient's relation to proband: \_\_\_\_\_

**If testing was not performed at CCHMC, please include proband's report and at least 100ng of proband's DNA to use as a positive control.**

### DELETION AND DUPLICATION ASSAY

Gene(s) to be analyzed (specify): \_\_\_\_\_  
 \_\_\_\_\_

Please see list of available genes at: [www.cincinnatichildrens.org/deldup](http://www.cincinnatichildrens.org/deldup)

Suspected syndrome/ condition: \_\_\_\_\_

Please choose one of the following:

- Deletion and duplication analysis of gene(s) specified above
- Deletion and duplication analysis of gene(s) specified above with reflex to sequencing, if indicated
- Analysis of gene(s) specified above from previously analyzed deletion and duplication
- Familial deletion analysis

Proband's name: \_\_\_\_\_

Proband's DOB: \_\_\_\_\_

Proband's variant: \_\_\_\_\_

Patient's relation to proband: \_\_\_\_\_

**If testing was not performed at CCHMC, please include proband's report and at least 100ng of proband's DNA to use as a positive control.**