

MITOCHONDRIAL DISORDERS TEST 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: Amniotic fluid Blood Cytobrushes

Cord blood CVS Bone marrow

Tissue (specify): _____

Specimen Date: ____ / ____ / ____ Time: _____

Specimen Amount: _____

Each test requires 3 mL of whole blood in EDTA tube. Please call before sending tissue samples.

DRAWN BY: _____

*Phlebotomist must initial tube of specimen to confirm sample identity

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:

- Diagnosis in symptomatic patient
- Carrier (Heterozygote) testing
- Presymptomatic diagnosis of at-risk sibling
- Prenatal testing (by previous arrangement only)
- Other: _____

TEST(S) REQUESTED**Mitochondrial DNA**

- Whole mitochondrial genome (mtDNA) sequencing **and** deletion/duplication analysis by next generation sequencing (NGS)
- Whole mitochondrial genome (mtDNA) sequencing by NGS
 - Reflex to deletion/duplication analysis by NGS, if warranted
- Whole mitochondrial genome (mtDNA) deletion/duplication analysis by NGS for breakpoint analysis
 - Reflex to mtDNA sequencing by NGS, if warranted
- Whole mitochondrial genome (mtDNA) deletion/duplication analysis by PCR gel methodology

mtDNA panels

- Common mutations mtDNA panel (mtDNA 1555, 3243, 3271, 3460, 8344, 8993, 11778, 14459, 14484)
- Common mutations mtDNA panel with reflex to mtDNA whole genome sequencing
- Neuromuscular disorders mtDNA panel (MELAS/MERRF: mtDNA 3243, 3271, 8344)
- Neuromuscular disorders mtDNA panel with reflex to mtDNA whole genome sequencing
- Leber Hereditary Optic Neuropathy mtDNA panel (mtDNA 3460, 11778, 14459, 14484)
- Leber Hereditary Optic Neuropathy mtDNA panel with reflex to mtDNA whole genome sequencing
- Hearing loss mtDNA panel (mtDNA 961, 1555, 1494, 3242, 3271, 7445, 7511, 8344)

POLG-related disorders: AD-PEO, SANDO, MIRAS

- POLG* full gene sequencing
 - Reflex to deletion/duplication of *POLG*

IBMPFD

- VCP* full gene sequencing
 - Reflex to deletion/duplication of *VCP*

 Targeted (family specific) mutation analysis of genes listed above

Gene of interest _____

Proband's name _____

Proband's DOB _____

Proband's mutation _____

Relationship to proband _____

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

CLINICAL HISTORY

Please describe the patient's symptoms and family history using the checklist below as a guideline. Please attach a pedigree if available:

Please describe previously abnormal tests – e.g. Metabolic tests, MRI, Echo, Muscle histology, and functional studies: _____

Proband Family

Neurological/Muscular Symptoms

- | | | |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures or epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic fatigue syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | ALS (Lou Gehrig's disease) |
| <input type="checkbox"/> | <input type="checkbox"/> | Tremor |
| <input type="checkbox"/> | <input type="checkbox"/> | Recurrent headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Alzheimer's disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Sensory Neuropathy |
| <input type="checkbox"/> | <input type="checkbox"/> | Recurrent vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | Paget Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral Palsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Contractures |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle weakness |
| <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia |
| <input type="checkbox"/> | <input type="checkbox"/> | Ataxia |
| <input type="checkbox"/> | <input type="checkbox"/> | Dysphagia |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular Dystrophy |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke-like episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle wasting |
| <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune Disease |

Developmental Histories

- | | | |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Autism |
| <input type="checkbox"/> | <input type="checkbox"/> | Learning Disabilities |
| <input type="checkbox"/> | <input type="checkbox"/> | Developmental Delay |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental Retardation |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Psychiatric Issues

- | | | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Bipolar Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | OCD |
| <input type="checkbox"/> | <input type="checkbox"/> | Panic attacks |
| <input type="checkbox"/> | <input type="checkbox"/> | Schizophrenia |
| <input type="checkbox"/> | <input type="checkbox"/> | Dementia Memory Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Gastrointestinal & Metabolic Disease

- | | | |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Recurrent vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable Bowel Syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | A known metabolic disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Ophthalmologic Problems

- | | | |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | CPEO (Ophthalmoplegia) |
| <input type="checkbox"/> | <input type="checkbox"/> | Cataracts Blindness |
| <input type="checkbox"/> | <input type="checkbox"/> | Ptosis (droopy eyelids) |
| <input type="checkbox"/> | <input type="checkbox"/> | Retinitis Pigmentosa |
| <input type="checkbox"/> | <input type="checkbox"/> | Color blindness |
| <input type="checkbox"/> | <input type="checkbox"/> | Macular degeneration |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual field defect |
| <input type="checkbox"/> | <input type="checkbox"/> | Optic atrophy |
| <input type="checkbox"/> | <input type="checkbox"/> | Corneal deposits |
| <input type="checkbox"/> | <input type="checkbox"/> | Photophobia |

Auditory Problems

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing impaired or deaf (please describe): _____ |
|--------------------------|--------------------------|---|

Cardiac Disease/Symptoms

- | | | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pains |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular heart beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiomyopathy |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Other Health Concerns

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes (adult or juvenile) |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Short stature |
| <input type="checkbox"/> | <input type="checkbox"/> | Early childhood deaths |
| <input type="checkbox"/> | <input type="checkbox"/> | SIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Multiple miscarriages or infertility |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer (please describe): _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Any other condition not listed here (please describe): _____ |
