

EXOMESEQ RE-ANALYSIS REQUEST FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____ / _____ / _____ CCHMC Accession number: MD - _ _ - _ _
Month Day Year

Referring Physician: _____ Date of Initial Report: _____

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 _____ / _____ / _____
Month Day Year
 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.

PHYSICIAN INFORMATION

Physician Name (print): _____ Address: _____
 Phone: (_____) _____ Fax: (_____) _____ Email: _____
 Genetic Counselor/Lab Contact Name: _____
 Phone: (_____) _____ Fax: (_____) _____ Email: _____

Referring Physician Signature (REQUIRED) _____ Date: _____ / _____ / _____
Month Day Year

TYPE OF RE-ANALYSIS

Exome Re-Analysis — Please complete information below:

New Phenotypic Information

If applicable, list any new indications identified in the proband since the original Whole Exome Sequencing was completed:

New Genes of Interest

If applicable, list new genes of interest that have recently been determined to be clinically significant for the proband's documented phenotype since the original Whole Exome Sequencing was completed:

Provider's Contact Information*

Provider's Phone number: _____

Provider's Email Address: _____

**All Exome Re-Analysis requests will be evaluated by a genetic counselor. The ordering clinician will be contacted with test recommendations prior to the initiation of testing.*

Note: Re-Analysis of ExomeSeq data may be requested within five years from the date of the initial exome case submission. Re-Analysis of ExomeSeq data will be performed at the coverage obtained during original order. A new sample may be required for confirmation studies if the initial ExomeSeq was performed more than 2 years ago, or if the sample was depleted during original testing.

Disclaimer: Results generated by re-analysis of ExomeSeq data are limited by specificity of the sequencing capture kit.