

# HERITABLE PANCREATIC DISEASE TESTING 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: Cincinnati Children's Patients, Cincinnati Children's 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  Saliva

Tissue (specify): \_\_\_\_\_

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

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

Each test requires 3 mL of whole blood in EDTA tube. Please call before sending alternate tissue samples, and for free cytobrush or saliva collection kits.

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:

- Chronic pancreatitis
- Acute recurrent pancreatitis
- Acute pancreatitis with family history
- Pancreatic insufficiency
- Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### CLINICAL HISTORY

- Chronic pancreatitis
- Acute pancreatitis
- Diabetes
- Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### TEST(S) REQUESTED

#### Pancreas Panels by Next-Generation Sequencing (NGS)

**Pancreas Panel**

(*CASR, CEL, CFTR, CLDN2, CPA1, CTRC, PRSS1, SBDS, SPINK1, UBR1*)

Reflex to deletion/duplication of *CASR, CFTR, CTRC, and SPINK1*

Reflex to deletion/duplication of single gene(s) (specify): \_\_\_\_\_

\_\_\_\_\_

**Pancreatic Insufficiency Panel**

(*CEL, CFTR, SBDS, UBR1*)

Reflex to deletion/duplication of *CFTR*

Deletion/Duplication analysis of *CEL, CLDN2, CPA1, SBDS, or UBR1* is not available at this time.

**Single Gene Testing\***

SBDS full sequence analysis

\*Please see the Custom Gene Sequencing section for single gene sequencing of all other Pancreas Panel genes

**Targeted (family specific) variant analysis of genes listed above**

Gene of interest: \_\_\_\_\_

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

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

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

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

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

### 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 variant analysis

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

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

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

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

**Please include proband's report, if not performed at CCHMC.**

#### 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)