Cincinnati Children's
changing the outcome together

GENETICS AND GENOMICS DIAGNOSTIC LABORATORY
For local courier service and/or inquiries, please contact 513-636-4474 • Fax: 513-636-4373
www.cincinnatichildrens.org/moleculargenetics • Email: LabGeneticCounselors@cchmc.org

Shipping Address:
3333 Burnet Avenue, Room R1042
Cincinnati, OH 45229

CIRCADIAN AND COMPLEX SLEEP 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: ☐ Blood ☐ Saliva ☐ DNA* ☐ Amniotic Fluid

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.

* Send 10mcg of high quality DNA . Only DNA that was extracted in a CLIA certified lab can be accepted.

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 Genetics and Genomics Diagnostic Laboratory 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.

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Patient Name: _____ Date of Birth: _____

INDICATIONS/DIAGNOSIS/ICD-10 CODE

Select all that apply:

- ☐ Insomnia
- ☐ Restless sleep
- ☐ Excessive daytime sleepiness
- ☐ Frequent nocturnal awakenings
- ☐ Advanced sleep phase syndrome (ASPS)
- ☐ Delayed sleep phase syndrome (DSPD)
- ☐ Non-24-hour sleep-wake disorders (N24)
- ☐ Irregular sleep-wake rhythm disorder (ISWRD)
- ☐ Restless leg syndrome (RLS)
- ☐ Periodic limb movement disorder (PLMD)
- ☐ Narcolepsy
- ☐ Hypersomnia
- ☐ Sleep apnea
- ☐ Short sleep cycle
- ☐ Long sleep time
- ☐ Complex disorder involving changes in sleep patterns and/or daytime symptoms that are not identifiable as a single sleep disorder
- ☐ Positive family history of:_____
  Please specify relationship :_____
- ☐ Other: _____

CLINICAL HISTORY

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

☐ Polysomnography/Multiple Sleep Latency results ☐ HLA results ☐ Other (please specify): _____

TEST(S) REQUESTED

☐ **Circadian and Complex Sleep Disorders Gene Sequencing Panel (143 genes)**

ADCY3, ADK, ADORA2A, ADRB1, AK5, APP, ARNTL, ARNTL2, ATP2B3, BDNF, BHLHE40, BHLHE41, BLOC1S6, BTBD9, CACNA1A, CACNA1B, CACNA1G, CAMK2A, CAMK2B, CAMTA1, CDKL5, CHRM1, CHRM3, CIART, CLOCK, CNTNAP2, CREB1, CREBBP, CRH, CRY1, CRY2, CSNK1A1, CSNK1D, CSNK1E, CUL3, DBH, DBP, DISC1, EGR3, ELP3, ERC2, FAAH, FABP7, FBXL3, FMR1, FOS, FOSB, FOXP1, FTO, FUS, GRIA1, GRIA3, GRIN1, GRM1, GRM2, GRM3, HCRT, HCRTR2, HDC, HLF, HOMER1, HOMER2, HTR1A, HTR1B, HTR2A, HTR2C, HTR7, HTT, IFNAR1, IL1R1, IL6, JAML, KANSL1, KCNA2, KCNA3, KCNC1, KCNK9, KCNN3, KCTD5, KPNB1, LEP, MAP2K5, MCHR1, MEIS1, MTOR, NALCN, NCKAP5, NFKB1, NLGN2, NLGN3, NLRP3, NOS1, NPAS2, NPRL3, NPSR1, NR1D1, NR1D2, NTSR1, OPN4, OPRM1, PANX1, PAX8, PCDHA3, PDE4D, PER1, PER2, PER3, PPARGC1A, PPP3CA, PPP3R1, PRKAB2, PRKG1, PRL, PRNP, PROK2, PTPA, PTPRD, RAB3A, RCAN2, RGS16, RIMS1, RORA, RORB, RORC, SCN1A, SHANK3, SHMT1, SIK3, SLC18A2, SLC29A1, SLC6A2, SLC6A3, SLC6A4, TEF, TIMELESS, TNF, TNFRSF1A, TNRC6B, TOX3, TRANK1, UBB, UBE3A, VAMP2

☐ **Reflex to Whole Exome Sequencing**

Whole exome sequencing (WES) orders require a signed WES Consent Form and completion of the WES Test Requisition. Also, inclusion of biological parental samples is strongly encouraged to assist with the analysis of WES and to increase test yield. Please visit our website at www.cincinnatichildrens.org/exome to obtain the required documents. WES testing will NOT be started until all forms are completed and received by the lab.

☐ **Targeted (family specific) variant 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 variant 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.

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)**

☐ 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

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.