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: moleculargenetics@cchmc.org

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

CUSTOM GENE SEQUENCING OR DELETION/DUPLICATION ASSAY 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 _____ / _____ /_____

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Uncertain/Other:_____

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 ☐ Bone marrow
☐ Cord blood ☐ CVS ☐ Cytobrushes ☐ DNA ☐ Saliva
☐ Tissue (specify): _____

Specimen Date: _____ / _____ / _____ Time: _____

Specimen Amount: _____

Please call before sending tissue samples.

DRAWN BY: _____
*Phlebotomist must initial tube of specimen to confirm sample identity.

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

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.

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Patient Name: _____ Date of Birth: _____

INDICATIONS/DIAGNOSIS/ICD-9 CODE

Reason for Testing:

☐ Mutation detection in suspected affected patient

☐ Carrier testing

☐ Pre-symptomatic diagnosis of at-risk relative

☐ Prenatal testing (by previous arrangement only)

Please call 513-636-4474 to discuss any prenatal testing with a genetic counselor prior to shipment.

PEDIGREE OR FAMILY HISTORY

Parental Consanguinity ☐ Y ☐ N

TEST(S) REQUESTED

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 mutation: _____

Patient's relation to proband: _____

If testing was not performed at Cincinnati Children's, 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 mutation: _____

Patient's relation to proband: _____

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

CLINICAL HISTORY

Symptoms: _____

Laboratory tests and results: _____

Previous genetic tests and results: _____

Medical procedures: _____

Medical imaging tests and results: _____

Other non-genetic diagnostics tests and results: _____