Cincinnati Children's™
changing the outcome together

MOLECULAR GENETICS LABORATORY

For 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

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: _____

_____ Date: _____/ _____/ _____
Referring Physician Signature (REQUIRED)   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.