

PEDIATRIC/ADULT GENETIC 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 _____ / _____ / _____

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

SPECIMEN INFORMATION

SPECIMEN TYPE: ☐ Peripheral blood ☐ Skin biopsy (site): _____

☐ Bone Marrow ☐ Saliva ☐ Cytobrushes ☐ Other: _____

***See Page 3 for a list of acceptable specimen types for each test**

Specimen Date: _____ / _____ / _____ Time: _____

Specimen Amount: _____

DRAWN BY: _____

INDICATIONS/DIAGNOSIS/ICD-10 CODE

- | | |
|--|---|
| ☐ ADD/ADHD | ☐ Failure to thrive |
| ☐ Acute myelogenous leukemia (AML) | ☐ Hydrocephalus |
| ☐ Amenorrhea: 1' or 2' | ☐ Hyper/Hypopigmentation |
| ☐ Aplastic Anemia | ☐ Hypotonia |
| ☐ Autism Spectrum Disorder | ☐ Immune deficiency |
| ☐ Broad thumbs and/or halluces | ☐ Intellectual disability |
| ☐ Congenital heart anomaly | ☐ Language disorder |
| ☐ Developmental Delay | ☐ Limb malformation |
| ☐ Dysmorphic features | ☐ MRI, abnormal |
| ☐ Encephalopathy | ☐ Macrocephaly |
| ☐ Eye anomaly | ☐ Microcephaly |
| ☐ Erythematous "butterfly" lesion on face | ☐ Myelodysplastic syndrome (MDS) |

- ☐ PDD-NOS
- ☐ Pancytopenia
- ☐ Seizures, convulsions
- ☐ Short stature
- ☐ Other: _____

Newborn Indications:

- ☐ Abnormal NIPT/prenatal screen
- ☐ Suspected trisomy 21
- ☐ Suspected Turner's syndrome
- ☐ Ambiguous genitalia
- ☐ Other: _____

Family History

- ☐ Family history of genetic condition: _____
- ☐ Consanguinity (describe relationship): _____
- ☐ Known Chromosome Abnormality: _____

BILLING INFORMATION (Choose ONE payment method)

☐ 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.

PROVIDER INFORMATION

Provider Name (print): _____

Address: _____

Phone: (_____) _____ Fax: (_____) _____

Email: _____

Genetic Counselor/Lab Contact Name: _____

Phone: (_____) _____ Fax: (_____) _____

Email: _____

_____ Date: ____/____/____

Referring Physician Signature (REQUIRED)

Contact information for results/questions (if different than ordering provider):

Name and Title: _____

Phone: (_____) _____ Fax: (_____) _____

Email: _____

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) | |

☐ 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.

TEST(S) REQUESTED CONTINUED

- ☐ Stickler Syndrome Gene Panel (13 genes)
BMP4, COL11A1, COL11A2, COL2A1, COL9A1, COL9A2, COL9A3, GZF1, LOXL3, LRP2, PLOD3, SOX9, VCAN
- ☐ Reflex to Cleft and Craniofacial Gene Panel
- ☐ REFLEX to Whole Exome Sequencing** (See additional details below)
- ☐ Treacher Collins Syndrome and Mandibulofacial Dysostosis Gene Panel (10 genes) *DHODH, EDNRA, EFTUD2, POLR1A, POLR1B, POLR1C, POLR1D, SF3B4, TCOF1, TXNL4A*
- ☐ Reflex to Cleft and Craniofacial Gene Panel
- ☐ REFLEX to Whole Exome Sequencing** (See additional details below)
- ☐ Other: _____

Whole exome sequencing (WES) orders require 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.

CUSTOM GENE SEQUENCING

Gene(s) to be analyzed (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 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: _____

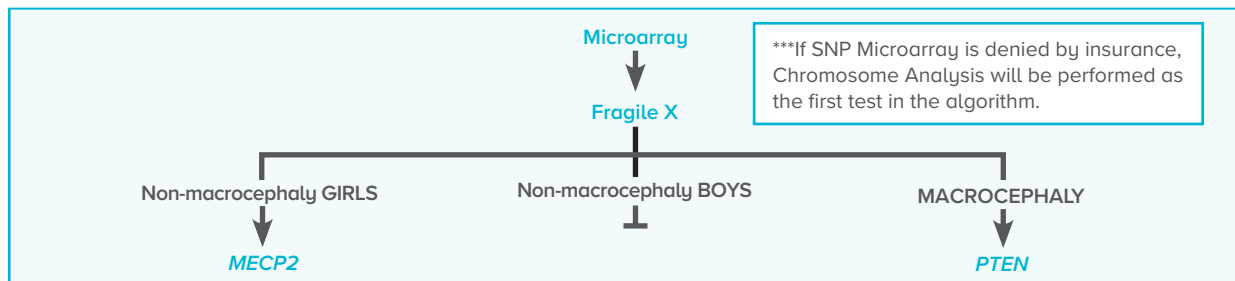
Proband's mutation: _____

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.

NEURODEVELOPMENTAL REFLEX GENETIC TESTING ALGORITHM

Tests will be performed sequentially based on the path that your patient follows in the Neurodevelopmental Reflex Test algorithm. Charges will apply to the tests completed in the patient's defined Neurodevelopmental Reflex Test algorithm. Testing will only proceed to the next step if the previous test result is uninformative.



SPECIMEN REQUIREMENTS

- **Routine & High Resolution Chromosome Analysis:**
3–5 mL blood (NaHep)
- **Optical Genome Mapping (OGM) Genome-wide and Targeted Analysis:**
3 mL blood (NaHep) or (EDTA), tissue (1cm x 1cm), or punch biopsy (2mm tissue in sterile transport media or saline)
- **SNP Microarray:**
3 mL blood (NaHep) and 3 mL blood (EDTA)
- **FISH Tests:** 1–3 mL blood (NaHep)
- **Neurodevelopmental Reflex Genetic Testing:**
3 mL blood (NaHep) and 3–5 mL blood (EDTA)
- **Fragile X DNA Testing:**
3 mL blood (EDTA)
- **Fanconi Anemia Chromosome Breakage Study:**
5–10 mL blood (NaHep), 5–10 mL bone marrow (NaHep), or skin biopsy (3–4 mm tissue in sterile transport media)
- **ABCD1 del/dup by MLPA, EpiSignature Complete, EpiSignature Targeted, MECP2 del/dup by MLPA, Prader-Willi/Angelman by MLPA, Spinal Muscular Atrophy - SMN1/SMN2 Copy Number Analysis & Deletion/Duplication Assay:** 3 mL blood (EDTA)
- **ABCD1, FANCA, FANCC, FANCG, MECP2, PTEN & Custom Gene Sequencing:** 3 mL blood (EDTA), saliva collection kit*, or 6 cytobrushes
- **Cleft and Craniofacial, Chromosome Breakage Disorders, Fanconi Anemia, Rubinstein-Taybi and Related Syndromes, Stickler Syndrome & Treacher Collins Syndrome and Mandibulofacial Dysostosis Gene Panels:**
3 mL blood (EDTA) or saliva collection kit*

*Call the office at 513-636-4474 to obtain saliva collection kits