RASopathy/Noonan Spectrum Disorders Panel, Parental Comparative Analysis Requisition	
Patient label	Cincinnati Children's Hospital Medical Center 240 Albert Sabin Way, Room S4.381 Cincinnati, OH 45229-3039 Phone: 513-803-1751 Fax: 513-803-1748

Specimen type: (MM/DD/YYYY)

☐ Blood ☐ DNA ☐ Other _____ Date Collected _____

PATIENT INFORMATION

First Name_____ MI _____ Last Name_____ ☐ M ☐ F ☐ Unknown

DOB _____ Street Address _____

City, State, Zip Code _____

Race:
- ☐ White
- ☐ Native American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Black or African American

Ethnicity:
- ☐ Hispanic
- ☐ Ashkenazi Jewish
- ☐ Other _____

(check all that apply)

GENE TEST TO BE PERFORMED

☐ **RASopathy/Noonan Spectrum Disorders Panel -** Parental comparative analysis

Name of Proband and MRN_____

_____

☐ **Prenatal Noonan Spectrum Disorders Panel** – Parental comparative analysis

Relationship to Proband_____

CLINICAL INFORMATION

Clinical Features–RASopathy/Noonan syndrome (check all that apply)

☐ Dysmorphology
- ☐ Low-set ears
- ☐ Ptosis
- ☐ Pectus
- ☐ Webbed neck
- ☐ Hypertelorism
- ☐ Short stature

Other pertinent features _____

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_____

Clinical Diagnosis:
- ☐ Cardiomyopathy
  - ☐ HCM
  - ☐ DCM
  - ☐ LVNC
  - ☐ RCM
- ☐ Conduction system disease
- ☐ Congenital heart disease
  - ☐ ASD
  - ☐ PS
  - ☐ VSD