Genetic Test Requisition Form

Institute for Genomic Medicine (IGM) Clinical Laboratory
Tel: (614) 722-5321 / Fax: (614) 722-5471

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

Laboratory Client Services
Tel: (614) 722-5477 / (800) 934-6575
NationwideChildrens.org/Lab

Ship Samples to: Nationwide Children's Laboratory Services
700 Children's Drive, Room C1955
Columbus, OH 43205 U.S.A.

PATIENT INFORMATION (Please Print or Place ID Label)

Last Name	First Name	MI

Date of Birth (DOB)	Sex Assigned at Birth	Gender Identity	SSN	Patient ID # / MRN
	☐ Male ☐ Female ☐ Unknown			

Street Address	City	State	Zip

Ethnicity (Check all that apply): ☐ European Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Native American ☐ Ashkenazi Jewish ☐ Other_____

ORDERING PHYSICIAN INFORMATION (Please Print)

Ordering Physician Name (REQUIRED)	**Phone (REQUIRED)**	**Fax (REQUIRED)**	NPI#

Attending Physician Information - **REQUIRED** if Ordering Physician is a Trainee (e.g. Resident, Fellow)

Attending Physician Name (**REQUIRED**)	Phone	Fax	NPI#

Institution / Practice / Facility Name

Street Address	City	State	Zip/Postal Code

Physician Email **(REQUIRED if sending from outside U.S.A.)**	Country (if not U.S.A.)

Ordering Physican Signature **X**	Date

ADDITIONAL REPORT TO SENDOUT LABORATORY (Please Print):

Name	Phone	Fax

SAMPLE INFORMATION (Please Print)

Collection Date	Collection Time ☐ AM ☐ PM	Collected by (Full Name)

Sample Type (Check ALL that apply): **Only the DNA isolated by a CLIA-certified lab or lab meting equivalent requirements are accepted.*
☐ Peripheral Blood ☐ Saliva ☐ Buccal Swab ☐ Stored DNA*, Accession#_____
☐ Cord Blood - molecular tests require 4 mL maternal EDTA blood for MCC ☐ Other, Specify _____

CLINICAL INFORMATION / ICD-10 (Please Print)

Reason for Testing (REQUIRED)	Is the Patient or Partner Currently Pregnant?
☐ for Diagnosis ☐ for Carrier Test	☐ No ☐ Yes-Gestational age: _____weeks _____days, EDC _____

History of Bone Marrow/Stem Cell Transplant?	Blood Transfusion Within 7 Days from Sample Collection?
☐ No ☐ Yes-Transplant date_____	☐ No ☐ Yes-Date_____, Type_____

Diagnosis / Clinical Findings (Attach clinical notes if available)	**ICD-10 Codes** (REQUIRED)

Family History (Attach pedigree if available) ☐ No relevant family history ☐ Positive family history (Describe in space below)

Family Member Name_____ DOB_____ ☐ Affected ☐ Carrier ☐ Unknown
Relationship to Patient_____ Gene_____ Variant_____
Tested at Nationwide Children's Lab ? ☐ Yes - Accession#_____ ☐ No - Lab Name_____

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Patient Name (or place patient ID label)

Last, First_____

DOB or MRN_____

BILLING INFORMATION

***Insurance Bill ONLY available if patient was NOT an inpatient at time of collection.**

- Insurance bill option is available for patients/insurance plans within the state of Ohio. For insurance bill, please attach the front and back copy of the patient's insurance card and complete the "Insurance Bill" section below.
- For out-of-Ohio patients/insurance plans, institutional bill option is preferred. We **DO NOT** have contracts with most insurance plans outside of Ohio.
- For **INTERNATIONAL** samples referred from outside the U.S.A. or Canada, we only accept institutional bill. Pre-payment or agreement of payment must be made **PRIOR TO** sending the sample. Payment can be made by wire transfer or by credit card. To arrange payment, please email *LaboratoryBilling@NationwideChildrens.org*.
- We **DO NOT** offer Self-pay option at this time.
- Please contact Laboratory Client Services for more information at 1-800-934-6575.
- **Please select ONE Billing method below. Billing selection must be completed to proceed with testing.**

☐ **INSTITUTIONAL/CLIENT BILL** (Please Print)	☐ **INSURANCE/PATIENT BILL** (Please Print) Please Attach a Front and Back Copy of Insurance Card
Billing Contact Name:	Legal Guardian Last Name:
Phone / Fax	Legal Guardian First Name, MI
Email Address (**Required**)	Legal Guardian DOB / Legal Guardian SSN
Institution / Hospital / Laboratory Name	Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other _____
Client Account Number (Please contact laboratorybilling@nationwidechildrens.org if you are unsure of your account number)	Subscriber Last Name
	Subscriber First Name, MI
Street Address	Subscriber DOB
City	Subscriber SSN
State / Province	Policy # / Group #
Zip Code	Insurance Company Name
Country	Insurance Address
☐ **Send a result copy to sending institution via:** ☐ Above Fax number ☐ Above Email address ☐ Other Fax/Email_____	City / State / Zip Secondary Insurance Company Name
Other Information:	

PATIENT CONSENT FOR INSURANCE BILL

I will fully abide with Nationwide Children's Hospital Laboratory Services by providing all necessary documents needed for insurance billing and appeals. I understand that I am responsible for the payment of this test whether through my insurance company or myself.

Patient Signature: X_____

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Last, First_____

DOB or MRN_____

EDTA (lavender-top); NaHep = Sodium Heparin (green-top), DO NOT use Lithium Heparin (also green-top); Test Code Listed Within [ ]

CYTOGENETIC TESTS

Chromosome Analysis - select applicable below:

- ☐ **Routine Chromosome Analysis, High Resolution Full Study** (20 cells studied, No Verbal Prelim Result) (4mL NaHep) [PBCS]
- ☐ **STAT Chromsome Analysis** (Verbal Preliminary Result in 2 Business Days, additional charges apply) (1-3mL NaHep) [STATPB]
- ☐ **Mosaicism Detection Study** (Up to 50 cells studied to evaluate for low-level chromosomal mosaicism)

☐ **Abbreviated Chromosome Analysis, 5-Cell Confirmation Study** (5 cells studied) (4mL NaHep) [PBC5CC]
Abbreviated blood chromosome analysis available for patients who need confirmation of previous cytogenetic test result.

☐ **FISH Analysis** (4mL NaHep) [FISHON] – Specify Syndrome/Probe/Locus_____

☐ **Microarray Analysis** (4mL EDTA) [SNPMA]

Parental Testing – Available if child previously had a cytogenetic test performed by Nationwide Children's Lab
Child's Name_____ Child's DOB_____ Test Accession#_____

- ☐ **Parental FISH Analysis** (4mL NaHep) [PFISH]
- ☐ **Parental Microarray Analysis** (4mL EDTA) [PSNPMA]

MOLECULAR GENETIC TESTS

☐ **DNA Isolation and Storage** (4mL EDTA) [DNASTOR] (if applicable, select below):

- ☐ Positive Control Sample
- ☐ Maternal Cell Contamination Studies

Proband/Previously Tested Family Member's Name_____ & DOB _____
Relationship to Above Individual _____ Test Accession#_____

☐ **Cystic Fibrosis Common Mutation Panel** (4mL EDTA) [CYSFIB]
☐ Carrier Screen or ☐ Diagnostic Test – If Diagnostic, is patient suspected of having CF? ☐ No ☐ Yes
Family History of CF? ☐ No ☐ Yes: Family member is ☐ Affected with CF ☐ Carrier of CF
If Yes, Relationship to Patient_____ & Mutation(s) if Known_____

☐ **Familial Variant Targeted Sequencing** (4mL EDTA) [FMLIS]
Proband/Previously Tested Family Member's Name_____ & DOB_____
Proband/Previously Tested Family Member is: ☐ Affected/Symptomatic ☐ Carrier/Asymptomatic ☐ Unknown
Gene_____ Variant(s)_____ Transcript (NM_#)_____
Gene_____ Variant(s)_____ Transcript (NM_#)_____
Gene_____ Variant(s)_____ Transcript (NM_#)_____
Relationship to This Patient_____
Affected/Carrier Family Member Tested at Nationwide Children's Lab ? ☐ No ☐ Yes: Accession#_____
If No, please also submit a sample from the affected/carrier family member to be used as a positive control sample.
Complete a separate requisition form for the family member and mark "DNA Isolation – Use as a Positive Control Sample."

☐ **Fragile X Syndrome, Repeat Number Analysis with Reflex to Methylation Analysis** (4mL EDTA) [FRAGX]
☐ Diagnostic Test or ☐ Carrier Test

Krabbe Disease (4 mL EDTA): ☐ ***GALC* Gene Common 30-kb Deletion Detection by PCR** [KDGALCCD]
☐ ***GALC* Gene Sequencing** [KDGALCSEQ]

☐ Mucopolysaccharidosis type I (MPS I), ***IDUA* Gene Sequencing** (4mL EDTA) [HSIDUA]

☐ **Prader-Willi Syndrome/Angelman Syndrome, Methylation Analysis** (4mL EDTA) [PWSASMETHYL]
Suspected Disorder: ☐ Prader-Willi Syndrome or ☐ Angelman Syndrome

☐ **Spinal Muscular Atrophy (SMA) Dosage Analysis** (4mL EDTA) [SMADOS]
☐ Diagnostic Test or ☐ Carrier Test

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Genome Sequencing Data Reanalysis

☐ **Reanalysis Genome Sequencing – Patient Sample** [GSREPAT]

- If the patient (child) previously participated in ***Genome sequencing*** **(GSPAT)** then submission of a **GS Reanalysis request form** is required. A new sample is not required. A new GS consent form is not required unless the patient (child) who previously had GS performed is now ≥18 and is able to provide consent.
- If the patient (child) previously participated in ***Rapid genome sequencing*** **(RGSPAT)** then submission of the **GS Reanalysis request form** and **GS consent form** is required. A new sample is not required.

Any new biological parent's sample to be submitted for Reanalysis? (e.g. from previously unavailable biological parent(s))

☐ No ☐ Yes – ☐ Mother's Sample, Name _____ DOB_____
Symptomatic? ☐ No ☐ Yes_____
☐ Father's Sample, Name _____ DOB_____
Symptomatic? ☐ No ☐ Yes_____

☐ **Reanalysis Genome Sequencing – Parent Sample** [GSREPAR] (4 mL EDTA – if new parent submitted)

- If the parent previously participated in the patient's (child's) ***Genome sequencing*** **(GSPAT)** then a new sample is not required. A new GS consent form is not required unless the parent is now ≥18 and is able to provide consent.
- If the parent previously participated in ***Rapid genome sequencing*** **(RGSPAT)** then submission of the **GS consent form** is required. A new sample is not required.
- If previously unavailable parent(s) will be participating in Genome Reanalysis, then submission of a **parental sample** (4 mL EDTA) and **GS consent form** are required. For additional parental sample requirements, please see test code: GSPAR.

Patient (Child) Participating in Reanalysis:
Name _____ DOB_____

Special Instructions / Notes:

Please check sample requirements and exclusions for each test on website Nationwidechildrens.org/Lab.

Ship Samples and Completed Test Requisition Form to:

Nationwide Children's Hospital Laboratory
700 Children's Drive, Room C1955
Columbus, OH 43205 U.S.A.

- Ship samples via Overnight Courier. Samples must arrive in the laboratory within 48 hours. Saturday deliveries accepted. Please check "Saturday Delivery" on shipment label.
- For questions regarding testing, specimen requirements or transport, please call IGM Clinical Laboratory at (614) 722-5321 or Lab Client Services at (800) 934-6575.