



Cardiology Next Generation Sequencing

Requisition Form

*Information required for testing

Patient Information

LAST NAME*		FIRST NAME*		MI	DOB* MM/DD/YYYY	SEX	GENDER
ADDRESS		CITY	STATE	ZIP CODE	PHONE NUMBER	EMAIL ADDRESS	

Billing Information (Please include a copy of insurance card(s) for billing purposes.)

*☐ CLIENT BILL ☐ INSURANCE ☐ SELF PAY ☐ MEDICARE/MEDICAID (☐ PRIMARY ☐ SECONDARY) RELATIONSHIP: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

INSURANCE NAME	MEMBER/POLICY ID	GROUP #
POLICY HOLDER NAME	POLICY HOLDER DOB MM/DD/YYYY	TEST INDICATION/ICD-10 CODE(S)*

Account Information

FACILITY/PRACTICE NAME*	PHONE NUMBER	FAX NUMBER	ORDERING PHYSICIAN NAME*
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Specimen Information PREFERRED SPECIMEN IS BUCCAL SWAB

☐ BLOOD IN EDTA (5ml MIN) ☐ BUCCAL SWAB ☐ DNA (10 ug MIN) COLLECTION DATE: MM/DD/YYYY COLLECTION TIME: 00:00 AM/PM

Background Information (Please check all that apply)

RACE AND ETHNICITY: ☐ WHITE ☐ ASIAN ☐ HISPANIC ☐ AFRICAN AMERICAN ☐ ASHKENAZI JEWISH ☐ OTHER (PLEASE SPECIFY):

GENE PANEL NAME* (Must choose at least one)	GENES **
<input type="checkbox"/> CARDIOLOGY FULL PANEL (ALL 174 GENES LISTED BELOW)	<input type="checkbox"/> INDIVIDUAL GENE TESTING: INDICATE BY CIRCLING GENES BELOW OR LISTING
<input type="checkbox"/> AORTOPATHY COMPREHENSIVE PANEL (24 GENES)	ACTA2, ABCG5, ABCG8, APOC2, APOE, CBS, COL3A1, COL5A1, COL5A2, EFEMP2, FBN1, FBN2, HCN4, MYH11, MYLK, NOTCH1, SLC2A10, SMAD3, SMAD4, TBX20, TGFB2, TGFB3, TGFB3R1, TGFB3R2
<input type="checkbox"/> ARRHYTHMIA & CARDIOMYOPATHY COMPREHENSIVE PANEL (134 GENES)	ABCC9, ACTA1, ACTC1, ACTN2, AKAP9, ALMS1, ANK2, ANKRD1, BAG3, BRAF, CACNA1C, CACNA2D1, CACNB2, CALM1, CALR3, CASQ2, CAV3, CBL, CBS, COX15, CRYAB, CSRP3, CTF1, DES, DMD, DNAJC19, DOLK, DPP6, DSC2, DSP, DTNA, EMD, EYA4, FHL1, FHL2, FKBP, FKTN, FXN, GAA, GATAD1, GJA5, GLA, GPD1L, HCN4, HFE, HRAS, HSPB8, ILK, JPH2, JUP, KCNA5, KCND3, KCNE1, KCNE2, KCNE3, KCNH2, KCNJ2, KCNJ5, KCNJ8, KCNQ1, KLF10, KRAS, LAMA2, LAMA4, LAMP2, LDB3, LMNA, LTBP2, MAP2K1, MAP2K2, MIB1, MURC, MYBPC3, MYH6, MYH7, MYL2, MYL3, MYLK2, MYO6, MYOZ2, MYPN, NEXN, NKX2-5, NPPA, NRAS, PDLIM3, PKP2, PLN, PRDM16, PRKAG2, PRKAR1A, PTPN11, RAF1, RANGRF, RBM20, RYR1, RYR2, SALL4, SCN1B, SCN2B, SCN3B, SCN4B, SCN5A, SCO2, SEPN1, SDHA, SLC6A1, SLC6A2, SLC6A3, SLC6A4, SLC6A5, SLC6A6, SLC6A7, SLC6A8, SLC6A9, SLC6A10, SLC6A11, SLC6A12, SLC6A13, SLC6A14, SLC6A15, SLC6A16, SLC6A17, SLC6A18, SLC6A19, SLC6A20, SLC6A21, SLC6A22, SLC6A23, SLC6A24, SLC6A25, 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Patient Name _____ **Patient DOB** _____

DISEASE/CONDITION	SELF (Circle Response)	RELATIVES (Indicate Maternal or Paternal side)	AGE AT DIAGNOSIS
Irregular heartbeat	Yes / No		
Cardiac muscle thickening or thinning	Yes / No		
Amyloidosis	Yes / No		
Disease of the aorta	Yes / No		
Connective Tissue Disorder	Yes / No		
Noonan Syndrome	Yes / No		
High cholesterol	Yes / No		
Congenital heart disease	Yes / No		
Heart attack	Yes / No		
Cardiac arrest	Yes / No		
Heart transplant	Yes / No		
Hardening and narrowing of the arteries	Yes / No		
Implantable cardioverter defibrillator	Yes / No		
High blood pressure	Yes / No		
High triglycerides	Yes / No		
Fainting during exercise	Yes / No		
Fainting during normal activity	Yes / No		
Problems with exercise	Yes / No		
Sudden unexpected death without a known cause	Not applicable		
Muscle weakness or muscle disorders (such as muscular dystrophy)	Yes / No		
Any other chronic or genetic diseases that run in your family: _____	Yes / No		
Any other cardiovascular condition not mentioned above: _____	Yes / No		

PREVIOUS GENETIC TESTING

If genetic testing HAS been done please fill out table below

☐ Check here if NO genetic testing has been done

Gene:	RefSeq#:	Variant:	Genebank Reference #:
Gene:	RefSeq#:	Variant:	Genebank Reference #:
Gene:	RefSeq#:	Variant:	Genebank Reference #:

(Provide HGVS Nomenclature or indicate if other)

Proband Name:	DOB (MM/DD/YYYY):	Lab or clinic Family #:
Relationship to Patient:		

ICD-10 CODES*

<input type="checkbox"/> I49.9	Cardiac arrhythmia, unspecified.	<input type="checkbox"/> I46	Cardiac arrest
<input type="checkbox"/> I42.9	Cardiomyopathy, unspecified	<input type="checkbox"/> Z94.1	Heart transplant status
<input type="checkbox"/> E85.9	Amyloidosis, unspecified	<input type="checkbox"/> I70	Atherosclerosis
<input type="checkbox"/> L94.9	Localized connective tissue disorder, unspecified.	<input type="checkbox"/> Z95.810	Presence of automatic (implantable) cardiac defibrillator
<input type="checkbox"/> Q87.19	Other congenital malformation syndromes predominantly associated with short stature	<input type="checkbox"/> I10	Hypertensive diseases
<input type="checkbox"/> E78.5	Hyperlipidemia, unspecified	<input type="checkbox"/> E78.1	Pure hyperglyceridemia
<input type="checkbox"/> Q24.9	Congenital malformation of heart, unspecified	<input type="checkbox"/> R55	Syncope and collapse
<input type="checkbox"/> I21	Acute myocardial infarction		