DDC clinic
Center for Special Needs Children

MOLECULAR DIAGNOSTICS LABORATORY

Molecular Diagnostics Laboratory at DDC Clinic
14567 Madison Rd., Middlefield, OH 44062
Phone: 440-632-5532 Fax: 440-632-1697
www.ddcclinicalab.org

Please complete all fields below. Missing or incomplete information may delay specimen processing.

PATIENT INFORMATION

Name (Last) _____ (First) _____ (Middle) _____ Date of Birth (MM/DD/YYYY) _____

Address (Street) _____

(City) _____ (State) _____ (Zip) _____ (Phone) _____

Race/Ethnicity: ☐ African American ☐ Caucasian ☐ Amish ☐ Other _____ Gender: ☐ Female ☐ Male ☐ Unknown/Not Reported

SPECIMEN INFORMATION

SPECIMEN SOURCE: ☐ Peripheral Blood ☐ Cord Blood ☐ DNA ☐ Other _____ (Please specify) Date Collected: (MM/DD/YYYY) _____

INDICATIONS FOR TESTING (Required)

REASONS FOR TEST (family history, clinical symptoms, etc.) AND ICD10 CODES: _____

RELEVANT CLINICAL AND LABORATORY INFORMATION: _____

REFERRING PHYSICIAN, CERTIFIED NURSE MIDWIFE, GENETIC COUNSELOR

Name _____ Title _____ NPI# (Required for insurance billing) _____

Institution, Practice, or Organization name _____ Address (Street) _____ (E-mail address) _____

(City) _____ (State) _____ (Zip) _____ (Phone) _____ (Fax) _____

Name and phone of contact person regarding this sample: _____

REPORT RESULTS TO ADDITIONAL PHYSICIAN, MIDWIFE, GENETIC COUNSELOR (If applicable)

Name _____ Title _____

Institution, Practice, or Organization name _____ Address (Street) _____ (E-mail address) _____

(City) _____ (State) _____ (Zip) _____ (Phone) _____ (Fax) _____

BILLING INFORMATION (Required)

Bill: ☐ Insurance Relationship of Patient to Insurance Holder: ☐ Self ☐ Child ☐ Spouse ☐ Other _____

Please attach a legible enlarged copy of the current insurance card (front and back) AND a signed copy of the Financial Responsibility Form

☐ Referring Institution _____

☐ Self-pay

TEST REQUESTED (Please specify)

☐ Chromosomal MicroArray Analysis

☐ Targeted Mutation Analysis (Specify Disease/Gene)

☐ Sequencing Panel (Specify Disease/Gene)

☐ Whole Gene Sequencing (Specify Disease/Gene)

TEST NAME / SHORT NAME / GENE(S): _____