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.ddccliniclab.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)

☐ Next Generation Sequencing ☐ Del/Dup ☐ NGS & Del/Dup Comprehensive ☐ Targeted Mutation ☐ Chromosomal Microarray

TEST NAME: _____
*(Specify disorder, gene name or panel name)*