Test Requisition

DDC clinic
Center for Special Needs Children
MOLECULAR DIAGNOSTICS LABORATORY
14567 Madison Rd.
Middlefield, OH 44062

Phone: (440) 632-1668
Fax: (440) 632-1697
www.ddcclinic.org

FOR LAB USE ONLY
TEST #_____
DATE REC'D_____
TIME REC'D

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)

Address (Institution, Practice, Organization) (Street)

(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/Organization (Phone) (FAX)

TEST REQUESTED (PLEASE SPECIFY)

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

SPECIFY DISEASE/GENE(S): _____

BILLING INFORMATION

☐ Commercial 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).

☐ Medicare (**Note: a signed ABN form MUST accompany the sample**)

☐ Medicaid (**Note: Only Ohio Medicaid plans accepted**)

☐ Referring Institution:_____

Billing contact name:_____ Phone:_____ FAX:_____

☐ Self-pay