DDC clinic
Center for Special Needs Children
Molecular Diagnostics Laboratory

Test Requisition

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_____

Specimen label MUST match the patient information found below to complete testing. Please complete all fields below that are marked "Required." Missing or incomplete information may delay specimen processing. This document MUST be included with the specimen sample. Samples without a label and/or test requisition cannot be processed.

PATIENT INFORMATION (REQUIRED)

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** **Not Reported**

SPECIMEN INFORMATION (REQUIRED)

Specimen Source: **Peripheral Blood** **Cord Blood** **DNA** **Other (Please Specify):** _____ / /

Date Collected (MM/DD/YYYY)

INDICATIONS FOR TESTING (REQUIRED)

Reasons for Test, ICD10 Codes, Other Relevant Clinical and Laboratory Information: _____

REFERRING PHYSICIAN, CERTIFIED NURSE MIDWIFE, GENETIC COUNSELOR (REQUIRED)

Name Title NPI# (Required for Insurance Billing)

Address (Institution, Practice, Organization) (Street) (City) (State) (Zip)

(Phone) (Fax) (Email)

DISCLAIMER: It is the responsibility of the ordering health care provider to explain the results and limitations of genetic testing to the patient and/or their legal guardian. By signing below, you acknowledge that you are the ordering health care provider and have received verbal consent from the patient and/or their legal guardian to order genetic testing.

Authorized Signature: _____ **Date:** _____

REPORT RESULTS TO ADDITIONAL PROVIDER (IF APPLICABLE)

(Name) (Institution/Practice/Organization) (Phone) (Fax)

TEST REQUESTED (REQUIRED)

☐ Genetic Awareness Panel (GAP) ☐ Targeted Variant Analysis (Please Specify): _____

☐ Chromosomal Microarray (CMA) ☐ Other (Please Specify): _____

BILLING INFORMATION (REQUIRED)

☐ **Self-Pay** ☐ **Amish Local Fund** _____ ☐ **BCMH** ☐ **Other (Please Specify):** _____

☐ **Referring Institution:** _____

(Institution) (Billing Contact Name) (Phone) (Fax)