

**Sample shipping address:**

**Washington University Department of Pathology & Immunology**  
 Clinical Support Office  
 425 S. Euclid Ave. | MSC 8024-14-4711 | St. Louis MO 63110  
 Tel: (314) 747-7337 | Fax: (314) 747-7336

**Sample drop-off locations:**

<b>Children's Hospital</b> One Children's Place Central Receiving 2N-25 St. Louis, MO 63110 Tel: (314) 454-4161	<b>North Campus Lab</b> Institute of Health (IOH) Core Lab 425 S. Euclid Ave.   Room 4701 St. Louis, MO 63110 Tel: (314) 362-1470
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**This requisition has two pages, please complete both pages to ensure testing.**

PATIENT IDENTIFICATION			PHYSICIAN ORDERING TEST <i>(NPI required)</i>		
Patient Status: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Office Visit			Name:		
Name Last:	First:	MI:	Institution:		
DOB (mm/dd/yyyy):	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		NPI:	Email:	
Medical Record # (if applicable):			Address:		
Address:			City:	State:	Zip:
City:	State:	Zip:	Phone:	Fax:	
Ethnicity (select all that apply)			Alternative Contact Information:		
<input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/NW European <input type="checkbox"/> E Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Jewish-Ashkenazi <input type="checkbox"/> Jewish-Sephardic <input type="checkbox"/> Mediterranean <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other			Phone:	Email:	
			Notes:		

SPECIMEN TYPE		
Date Collected (mm/dd/yyyy):	Time:	Directions 1. Draw 3-5 ml of peripheral blood in lavender top EDTA tube 2. Label tube with patient first/last name, DOB, and collection date/time 3. Place tube in a biohazard bag and form into document sleeve of the biohazard bag ensuring no patient information is visible 4. Ship specimen overnight in appropriate packaging at room temperature or with cold pack (Monday-Thursday only)
Collected By:		
Sample Type (Select one)		
<input type="checkbox"/> Peripheral Blood <input type="checkbox"/> Other:		

**REASON FOR TESTING *(Required-failure to include diagnosis may delay testing)***

Diagnosis:  
 ICD10 Code(s):

**TESTING REQUESTED** Testing is performed by exome capture next generation sequencing of the coding regions of relevant genes, which detects small sequence variants. Starred tests (\*) include additional testing by an alternate methodology when sequencing does not identify genetic alterations consistent with a molecular diagnosis. Core gene panels are comprised of genes established as causal for the relevant clinical condition. Expanded gene panels include analysis of all genes found in the core panel plus additional genes of uncertain significance that are implicated in the condition or indication. Please reference <https://gps.wustl.edu/patient-care/cardiac-disease/> for full details on ordering of core versus expanded cardiac panels.

**Please see website (gps.wustl.edu) for gene lists and details on the ordering of core versus expanded gene panels.**

<input type="checkbox"/> *Cardiac Disease gene panel with interpretation <input type="checkbox"/> Core 82 genes, <input type="checkbox"/> Expanded genes 150 <input type="checkbox"/> *Arrhythmia panel with interpretation <input type="checkbox"/> Core 13 genes, <input type="checkbox"/> Expanded 35 genes <input type="checkbox"/> Brugada Syndrome with interpretation <input type="checkbox"/> Core 1 gene, <input type="checkbox"/> Expanded 17 genes <input type="checkbox"/> *Catecholaminergic Polymorphic Ventricular Tachycardia panel with interpretation <input type="checkbox"/> Core 7 genes <input type="checkbox"/> *Long QT Syndromes panel with interpretation <input type="checkbox"/> Core 10 genes, <input type="checkbox"/> Expanded 16 genes <input type="checkbox"/> *Cardiomyopathy panel with interpretation <input type="checkbox"/> Core 52 genes, <input type="checkbox"/> Expanded 96 genes	<input type="checkbox"/> *Arrhythmogenic Right Ventricular Cardiomyopathy panel with interpretation <input type="checkbox"/> Core 11 genes, <input type="checkbox"/> Expanded 17 genes <input type="checkbox"/> *Dilated Cardiomyopathy panel with interpretation <input type="checkbox"/> Core 33 genes, <input type="checkbox"/> Expanded 68 genes <input type="checkbox"/> Hypertrophic Cardiomyopathy panel with interpretation <input type="checkbox"/> Core 28 genes, <input type="checkbox"/> Expanded 42 genes <input type="checkbox"/> *Familial Thoracic Aortic Aneurysm and Dissection panel with interpretation <input type="checkbox"/> Core 18 genes, <input type="checkbox"/> Expanded 25 genes
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<b>Targeted testing for known familial variant</b>	<b>Gene:</b>	<b>Variant:</b>
Please include copy of proband report		Relationship to patient above:

**ADDITIONAL NOTES:**

**Healthcare Professional Signature to Authorize Testing, Statement of Medical Necessity and Transmission of Results Verification**  
 I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested and Informed Consent has been obtained, as well as any other consent from the patient required by my state in order to perform a genetic test on a specimen has been obtained. I further certify that the test(s) requested is/are medically necessary and the results of this test will be used in the medical management of the patient.

The undersigned Client authorizes the Washington University School of Medicine to send Protected Healthcare Information (PHI) as identified in the Health Insurance Portability and Accountability Act (HIPAA) to the facsimile phone number above. Client acknowledges they are solely responsible for adopting and implementing appropriate policies and procedures, including physical safeguards, so that the location and use of the facsimile machine complies with all applicable HIPAA regulations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Below, office use only:*

Date/Time Received: \_\_\_\_\_ Accession Number: \_\_\_\_\_ Technician Initial: \_\_\_\_\_

**PATIENT INFORMATION**

Last Name:	First Name:	MI:	DOB (mm/dd/yyyy):
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**BILLING INFORMATION  
(CHECK ONE)**
 **Bill Patient/Insurance-Complete Section A**
 **Bill Submitting Institution-Complete Section B**
**SECTION A-PATIENT/INSURANCE BILLING INFORMATION**

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. For MEDICAID patients, Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered services. Other out-of-state welfare programs cannot be billed. Please contact our Patient Accounts Manager office at (314) 362-5641 or via email at [path-billing@email.wustl.edu](mailto:path-billing@email.wustl.edu) for complete insurance filing information and the managed care contract list.

Prior Authorization Number:	ICD10 Code(s):
CPT Codes and Unit Authorized:	

**ATTACH COPY OF INSURANCE CARD (if not available, complete the following)**

Policy Holder's Name			Insurance Co. Name:	
Last:	First:	MI:	Insurance Co. Phone:	
Policy Holder's Date of Birth (mm/dd/yyyy):			Plan Name:	
Relationship to Patient:			ID#:	Group#:

**SECTION B-INSTITUTIONAL BILLING**

Institution Name:				
Contact Name:			PO Number (if applicable):	
Email:				
Accounts Payable Billing Address:				
City:		State:		ZIP:
Phone:		Fax:		