

**JOHN WELSH CARDIOVASCULAR DIAGNOSTIC LABORATORY**  
**BAYLOR COLLEGE OF MEDICINE, FEIGIN CENTER, DEPARTMENT OF PEDIATRIC CARDIOLOGY**  
 1102 Bates, FC.480.02, Houston, TX 77030 Tel: (832) 824-4152  
 Fax: (832) 825-5159 E-mail: yuxinf@bcm.edu  
 Website: <http://www.bcm.edu/pediatrics/welsh>

DATE SAMPLE DRAWN: \_\_\_\_/\_\_\_\_/\_\_\_\_ SAMPLE TYPE:  BLOOD  OTHER (SPECIFY): \_\_\_\_\_

**COMPLETE A FORM FOR EACH SAMPLE SUBMITTED**

PATIENT NAME: \_\_\_\_\_  
 DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX:  M  F  UNKNOWN  
 ADDRESS: \_\_\_\_\_  
 CITY, STATE, ZIP: \_\_\_\_\_  
 HOME PHONE: (\_\_\_\_) \_\_\_\_\_ WORK: (\_\_\_\_) \_\_\_\_\_

**ETHNIC BACKGROUND**

- |   |   |
|---|---|
| <input type="checkbox"/> EUROPEAN CAUCASIAN     | <input type="checkbox"/> ASHKENAZI JEWISH |
| <input type="checkbox"/> OTHER JEWISH           | <input type="checkbox"/> ASIAN            |
| <input type="checkbox"/> HISPANIC               | <input type="checkbox"/> AFRICAN AMERICAN |
| <input type="checkbox"/> NATIVE AMERICAN INDIAN | <input type="checkbox"/> OTHER: _____     |

**REPORTING INFORMATION**

**PHYSICIAN/INSTITUTION:** \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 CITY, STATE, ZIP: \_\_\_\_\_  
 TELEPHONE: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_  
 SIGNATURE: \_\_\_\_\_

**GENETIC COUNSELOR/LABORATORY:** \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 CITY, STATE, ZIP: \_\_\_\_\_  
 TELEPHONE: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_  
 SIGNATURE: \_\_\_\_\_

**GENE SEQUENCING ANALYSIS: CHECK THE PANEL(S) OR THE TEST(S) REQUESTED**

- |  |  |
|--|--|
| <p><input type="checkbox"/> <b>PANEL A: Marfan Syndrome and MFS-Related Disorders</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>FIBRILLIN 1 (FBN1)</i> SEQUENCING</li> <li><input type="checkbox"/> <i>TGF-BETA RECEPTOR 1 (TGFB1)</i> SEQUENCING</li> <li><input type="checkbox"/> <i>TGF-BETA RECEPTOR 2 (TGFB2)</i> SEQUENCING</li> <li><input type="checkbox"/> <i>ACTIN ALPHA 2 (ACTA2)</i> SEQUENCING</li> <li><input type="checkbox"/> <i>MYOSIN HEAVY CHAIN 11 (MYH11)</i> SEQUENCING</li> </ul> <p><input type="checkbox"/> <b>PANEL B: Congenital Heart Disease (CHD)--Holt-Oram Syndrome, ASD, TOF, Heterotaxy, RVOT, TGA, DORV</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>TBX5</i> SEQUENCING</li> <li><input type="checkbox"/> <i>NKX2.5</i> SEQUENCING</li> </ul> <p><input type="checkbox"/> <b>PANEL C: Dilated Cardiomyopathy--DCM</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>DESMIN (DES)</i> SEQUENCING</li> <li><input type="checkbox"/> <i>LAMIN A/C (LMNA)</i> SEQUENCING</li> <li><input type="checkbox"/> <i>TAFAZZIN (TAZ, G4.5)</i> SEQUENCING</li> <li><input type="checkbox"/> <i>LAMP2</i> SEQUENCING</li> <li><input type="checkbox"/> <i>ZASP/CYPHER/LDB3</i> SEQUENCING</li> </ul> <p><input type="checkbox"/> <b>PANEL D: Left Ventricular Noncompaction--LVNC</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>TAFAZZIN (TAZ, G4.5)</i> SEQUENCING</li> <li><input type="checkbox"/> <i>ZASP/CYPHER/LDB3</i> SEQUENCING</li> <li><input type="checkbox"/> <i>LAMIN A/C (LMNA)</i> SEQUENCING</li> </ul> <p><input type="checkbox"/> <b>PANEL E: Muscular Dystrophies with Cardiomyopathy</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>LAMIN A/C (LMNA)</i> SEQUENCING</li> <li><input type="checkbox"/> <i>CAVEOLIN 3 (CAV3)</i> SEQUENCING</li> <li><input type="checkbox"/> <i>EMERIN (EMD)</i> SEQUENCING</li> <li><input type="checkbox"/> <i>ZASP/CYPHER/LDB3</i> SEQUENCING</li> <li><input type="checkbox"/> <i>DESMIN (DES)</i> SEQUENCING</li> </ul> | <p><input type="checkbox"/> <b>PANEL F: Hypertrophic Cardiomyopathy--HCM</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>CAVEOLIN 3 (CAV3)</i> SEQUENCING</li> <li><input type="checkbox"/> <i>SCO2</i> SEQUENCING</li> <li><input type="checkbox"/> <i>SURF1</i> SEQUENCING</li> <li><input type="checkbox"/> <i>LAMP2</i> SEQUENCING</li> <li><input type="checkbox"/> <i>ZASP/CYPHER/LDB3</i> SEQUENCING</li> </ul> <p><input type="checkbox"/> <b>PANEL G: Long QT Syndrome--LQTS</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>KCNJ2</i> SEQUENCING</li> <li><input type="checkbox"/> <i>CAVEOLIN 3 (CAV3)</i> SEQUENCING</li> </ul> <p><input type="checkbox"/> <b>PANEL H: Other Arrhythmia Disorders</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>CALSEQUESTRIN 2 (CASQ2)</i> SEQUENCING</li> <li><input type="checkbox"/> <i>DESMIN (DES)</i> SEQUENCING</li> <li><input type="checkbox"/> <i>KCNJ2</i> SEQUENCING</li> </ul> <p><input type="checkbox"/> <b>PANEL I: Sudden Infant Death Syndrome--SIDS</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>CAVEOLIN 3 (CAV3)</i> SEQUENCING</li> </ul> <p><input type="checkbox"/> <b>PANEL J: Atrioventricular Block</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>LAMIN A/C (LMNA)</i> SEQUENCING</li> <li><input type="checkbox"/> <i>DESMIN (DES)</i> SEQUENCING</li> <li><input type="checkbox"/> <i>EMERIN (EMD)</i> SEQUENCING</li> <li><input type="checkbox"/> <i>NKX2.5</i> SEQUENCING</li> </ul> <p><input type="checkbox"/> <b>Testing for Known Familial Mutation--KFM</b></p> <p>GENE: _____ MUTATION: _____</p> <p>Provide copy of report if testing done at another lab</p> |
|--|--|

**INDICATION FOR GENETIC TESTING**

- SYMPTOMATIC INDIVIDUAL**
- |   |   |
|---|---|
| <input type="checkbox"/> POSSIBLE DIAGNOSIS | <input type="checkbox"/> DEFINITE DIAGNOSIS |
|---|---|
- ASYMPTOMATIC INDIVIDUAL**
- |  |  |
|--|--|
| <input type="checkbox"/> PREVIOUS AFFECTED CHILD | <input type="checkbox"/> CARRIER SCREEN    |
| <input type="checkbox"/> FAMILY HISTORY          | <input type="checkbox"/> PREGNANCY AT RISK |

Upon completion of testing, patient DNA sample may be used for anonymized research studies.  YES  NO

**FAMILY HISTORY/CLINICAL SYMPTOMS: Please Complete**

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**VIRAL PCR ANALYSIS: CHECK THE TEST(S) REQUESTED**

- |  |  |
|--|--|
| <input type="checkbox"/> ADENOVIRUS  | <input type="checkbox"/> RESPIRATORY SYNCYTIAL VIRUS |
| <input type="checkbox"/> CYTOMEGALOVIRUS   | <input type="checkbox"/> INFLUENZA A VIRUS           |
| <input type="checkbox"/> ENTEROVIRUS   | <input type="checkbox"/> RUBELLA VIRUS               |
| <input type="checkbox"/> EPSTEIN-BARR VIRUS  | <input type="checkbox"/> MUMPS VIRUS                 |
| <input type="checkbox"/> PARVOVIRUS  | <input type="checkbox"/> HEPATITIS C VIRUS           |
| <input type="checkbox"/> VIRUS PANEL (Adenovirus, CMV, EBV, Enterovirus, Parvovirus) |  |

**BILLING INFORMATION**

**ONE OF THE TWO FOLLOWING BILLING OPTIONS MUST BE INDICATED BELOW.**

The Self-Pay option must include payment with sample. If the Billing Information section is incomplete, the referring physician/laboratory will be automatically charged, or sample processing will not be initiated.

**PAYMENT METHOD:**

- SELF-PAY(PAYMENT-IN-FULL):**
- CHECK OR MONEY ORDER
- AMEX/MASTERCARD/VISA/DISCOVER: PLEASE COMPLETE THE CREDIT CARD AUTHORIZATION FORM

**REFERRING INSTITUTION/MD:**

INSTITUTION CODE(As Assigned): \_\_\_\_\_

INSTITUTION NAME: \_\_\_\_\_

FINANCIAL CONTACT: \_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

TELEPHONE: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION**

I AUTHORIZE ANY PHYSICIAN OR LAB WHO HAS TREATED ME OR MY DEPENDENT(S) TO FURNISH ANY MEDICAL INFORMATION REQUESTED.

PRINTED NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**ESTIMATED TURNAROUND TIMES (TAT)**

**GENE SEQUENCING ANALYSIS:**

GENE	TAT	GENE	TAT
ACTA2	2-4 WEEKS	TBX5	2-4 WEEKS
CAV3	2-4 WEEKS	TGFBR1	2-4 WEEKS
DES	2-4 WEEKS	TGFBR2	2-4 WEEKS
EMD <input type="checkbox"/>	2-4 WEEKS	CASQ2	4-6 WEEKS
KCNJ2	2-4 WEEKS	LMNA	4-6 WEEKS
LAMP2	2-4 WEEKS	MYH11	4-6 WEEKS
NKX2.5	2-4 WEEKS	TAZ	4-6 WEEKS
SCO2	2-4 WEEKS	ZASP	4-6 WEEKS
SURF1	2-4 WEEKS	FBN1	6-8 WEEKS

**PRENATAL GENETIC TESTING: 2-4 WEEKS**

**KNOWN FAMILIAL MUTATION: 1-2 WEEKS**

**VIRAL TESTING: 1-2 WEEKS**

**SAMPLE SHIPPING INFORMATION**

**SEND SAMPLES MONDAY THRU THURSDAY OVERNIGHT TO:**

The John Welsh Cardiovascular Diagnostic Laboratory  
 Baylor College of Medicine, Feigin Center  
 1102 Bates, Rm FC.480.02  
 Houston, TX 77030