

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

INDICATION FOR GENETIC TESTING

- SYMPTOMATIC INDIVIDUAL**
- POSSIBLE DIAGNOSIS DEFINITE DIAGNOSIS
- ASYMPTOMATIC INDIVIDUAL**
- PREVIOUS AFFECTED CHILD CARRIER SCREEN
- FAMILY HISTORY 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"/> 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
CAV3	2-4 WEEKS	TBX5	2-4 WEEKS
DES	2-4 WEEKS	TGFBR1	2-4 WEEKS
EMD <input type="checkbox"/>	2-4 WEEKS	TGFBR2	2-4 WEEKS
KCNJ2	2-4 WEEKS	CASQ2	4-6 WEEKS
LAMP2	2-4 WEEKS	LMNA	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