Ann & Robert H. Lurie Children's Hospital of Chicago

Molecular Diagnostics Laboratory
2515 N. Clark St. Deming Bldg., Room 5027
Chicago IL 60614

Tel: 312.227.6130 Fax: 312.227.9456

Patient Sticker

Request for Congenital Central Hypoventilation Syndrome (CCHS) PHOX2B Custom Requisition

Created: 1/11/2019

Patient Information

Last name, First name

Name_____

MR # _____ DOB_____

Gender: M F ICD-10_____

ICD-10 _____ ICD-10 _____

o Fax results to: _____
phone #

Specimen Collection: Peripheral Blood

Date ordered: _____

Collect date: _____ Time: _____ AM PM

Collected by: ☐ Lab ☐ RN/MD _____

Provider address

Provider phone number

Physician Information

Ordering provider: _____

Signature:_____

Copy result to:_____

Specimen Collection: Genomic DNA

Extraction Date: _____

Name of Lab that Performed Extraction: _____

CLIA# of Lab that Performed Extraction: _____

Additional Information

For inquiries on the sequencing test, deletion/duplication test, specimen requirements, or this requisition, please contact Kai Lee Yap, PhD at Klyap@luriechildrens.org

Molecular Diagnostics Laboratory

	Test Name	EAP Order Code	CPT Code
☒	PHOX2B ANALYSIS FULL SEQUENCING	80510241	81404
☐	PHOX2B DUPLICATION DELETION VARIANT	80410114	81403
☐	PHOX2B KNOWN FAMILIAL VARIANT	80100169	81403, G0452

Miscellaneous/Other

	Test Name	EAP Order Code	CPT Code
☒			
☐		N/A	
☐		N/A	
☐		N/A	
☐		N/A	
		N/A	

Only tests that are medically reasonable and necessary for the diagnosis or treatment of a Medicare or Medicaid patient will be reimbursed. The Office of the Inspector General takes the position that a physician who orders medically unnecessary tests for which Medicare or Medicaid reimbursement is claimed may be subject to civil penalties under the False Claims Act.

o The patient/family has been informed that this requisition does not require the tests be performed by Lurie Children's Hospital. It was recommended to check with their insurance provider about coverage for these tests.

Patient Information and Billing Form – Phox2B

PLEASE THOROUGHLY COMPLETE THIS FORM TO AVOID DELAYING THE PROCESSING OF THE SAMPLE.

Patient Information: ***If submitting samples from multiple family members, please attach a pedigree.***

Last Name: _____ First Name: _____

Date of Birth: _____ _____ _____ Gender: ☐Male ☐Female
Month Day Year

Ethnicity: ☐ African American ☐ Asian Pacific Islander ☐ Caucasian ☐ Hispanic
☐ Other, please specify: _____

Contact Person: _____ Relationship to Patient: _____

Phone Number: _____ Mobile Number: _____

Address: _____

City_____ State: _____ Zip Code: _____

Reason for Ordering Test: _____

Diagnosis (check all that apply):

☐ CCHS ☐ Hirschsprung Disease ☐ Neuroblastoma ☐ Other Neural Crest Tumor
☐ Cardiac Pacemaker ☐ Esotropia ☐ Exotropia ☐ Fixed and Dilated Pupils
☐ Apparent Life Threatening Events (ALTEs) ☐ Unresolved apnea of prematurity ☐ Unresolved apnea of infancy

Age at diagnosis of alveolar hypoventilation: _____

Other pertinent information: _____

Asleep Ventilator Needs:

☐ Mechanical ventilation via tracheostomy
☐ BiPAP via mask ventilation
☐ Negative pressure ventilation
☐ Diaphragmatic pacers

Peak end tidal carbon dioxide: _____

Nadir hemoglobin during spontaneous breathing:

_____

Awake Ventilator Needs:

☐ Mechanical ventilation via tracheostomy
☐ Diaphragmatic pacers
☐ Tracheostomy

Peak end tidal carbon dioxide: _____

Nadir hemoglobin during spontaneous breathing:

_____

Billing Information: ***Ann & Robert H. Lurie Children's Hospital of Chicago will not bill third party payors for PHOX2B testing. Payment is the responsibility of the submitting entity. Pre-payment by cashier's check or credit card is required for all samples referred from outside of the United States.***

Direct Billing:

☐ Check enclosed (payable to Ann & Robert H. Lurie Children's Hospital of Chicago)

Credit Card (please indicate): ☐ Visa ☐ MasterCard ☐ Discover

Account Number: _____ Expiration Date: _____ CVC: _____

Cardholders Name: _____ Cardholders Phone Number: _____

Cardholders Address: _____

City_____ State: _____ Zip Code: _____

Cardholders Signature: _____ Date: _____

Institutional Billing (US ONLY):

Contact Person/Title: _____

Name of Institution: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Address: _____

City_____ State: _____ Zip Code: _____

Shipping Information: **Molecular Diagnostic Laboratories**
2515 N. Clark St.
Deming Building, Room 5027
Chicago, IL 60614

Phone: 312-227-6130
Fax: 312-227-9456

* *Additional information and medical records may be requested.*