

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 # _____ OR _____
 DOB _____
 Gender: M F ICD-10 _____
 ICD-10 _____ ICD-10 _____

Specimen Collection: Peripheral Blood

Date ordered: _____
 Collect date _____ Time: _____ AM PM
 Collected by: Lab
 RN/MD

Fax results to: _____
 phone # _____

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

X	Test Name	EAP Order Code	CPT Code
<input type="checkbox"/>	POX2B ANALYSIS FULL SEQUENCING	80510241	81404
<input type="checkbox"/>	POX2B DUPLICATION DELETION VARIANT	80410114	81403
<input type="checkbox"/>	POX2B KNOWN FAMILIAL VARIANT	80100169	81403, G0452

Miscellaneous/Other

X	Test Name	EAP Order Code	CPT Code
<input type="checkbox"/>		N/A	
<input type="checkbox"/>		N/A	
<input type="checkbox"/>		N/A	
<input type="checkbox"/>		N/A	
<input type="checkbox"/>		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.

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
 Cardia 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 Saturday during spontaneous breathing: _____

Awake Ventilator Needs:

- Mechanical ventilation via tracheostomy
 Diaphragmatic pacers
 Tracheostomy
Peak end tidal carbon dioxide: _____
Nadir hemoglobin Saturday 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.