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Clinical Questionnaire for General Cardiology NGS

Prior authorization questions, call **(866) 248-1265.** / Fax (**855) 711-5699** / Test questions, call (**800) 345-4363.**

Name and title of person completing this form _____

Test Information (this is not an order for a test)

Test Options	Test No.
◯ Familial Hypercholesterolemia Panel	**482261**
◯ Early-onset CAD /FH Panel	**482243**

Test Options	Test No.
◯ Familial Congenital Heart Disease Panel	**482318**
◯ Other	

Patient Demographics

Patient's name _____ / Date of birth_____ / Sex: ◯ Male ◯ Female

Patient/guardian phone no. _____ / Patient/guardian email _____

Patient History

Select at least one: ◯ Genetic counseling performed by board-certified genetic counselor or clinical geneticist. If marked, attach genetic counseling report.
◯ Pretest counseling performed by ordering provider or designee in accordance with health plan policies. Post-test counseling will be available

Select all that apply:

Familial Hypercholesterolemia (FH)
- ◯ Meets Dutch lipid criteria or Simon Broome lipid criteria for possible or probable FH
- ◯ First degree relative or family history of elevated lipid levels
- ◯ Plasma total cholesterol >310 mg/dL in an adult or >230 ng/dL in a child
- ◯ Tendon xanthomas in subject or family members
- ◯ Sudden premature cardiac death in a family member

Early onset coronary artery disease
- ◯ Findings through echocardiogram or electrocardiogram suggestive of early coronary artery disease
- ◯ Family member with cardiac arrest or myocardial infarction at <55 years of age (female) and <45 years of age (male)

Familial congenital heart disease
- ◯ Aortic stenosis
- ◯ Ventricular septal defect (VSD)
- ◯ Atrial septal defect (ASD)
- ◯ Tetralogy of fallot
- ◯ Atrioventricular septal defect
- ◯ Hypoplastic left heart syndrome
- ◯ Aortic valve disease

Alagille Syndrome
- ◯ Pulmonic stenosis
- ◯ Tetralogy of fallot
- ◯ Jaundice or signs of liver damage
- ◯ Ventricular septal defect
- ◯ Distinct facial features of Alagille

CHARGE Syndrome
- ◯ Patient meets either Blake or Verloes criteria
- ◯ Coloboma or microphthalmia
- ◯ Heart defects
- ◯ Choanal atresia or stenosis
- ◯ Growth retardation
- ◯ Genital abnormalities
- ◯ Ear abnormalities
- ◯ Cranial nerve dysfunction

Holt-Oram Syndrome
- ◯ Skeletal abnormalities of the hands and arms
- ◯ Atrial septal defect
- ◯ Ventricular septal defect
- ◯ Cardiac conduction disease
- ◯ Bradycardia

DiGeorge Syndrome
- ◯ Cleft palate or gap in palate
- ◯ Heart murmur
- ◯ Poor circulation
- ◯ Delayed growth and development
- ◯ Difficulty feeding, failure to gain weight or gastrointestinal problems
- ◯ Breathing problems
- ◯ Poor muscle tone
- ◯ Learning delays or disabilities
- ◯ Behavior problems

Family History (attach additional pages if needed)

- ◯ Patient has a first or second degree relative* with a clinical or suspected diagnosis of the conditions or genes for which they are being tested
- ◯ Patient has a first or second degree relative with sudden premature cardiac death or heart attack
- ◯ Previous pregnancy, loss or birth affected with DiGeorge Syndrome (22q syndrome)

Genetic Counseling—Ordering provider understands by signing below:
If genetic counseling by a board-certified genetic counselor is required by the health plan prior to laboratory testing but has not occurred as indicated in the Patient History section above, I understand that a referral may be made by the laboratory to a board-certified genetic counselor required or authorized by the health plan.
Such referral is solely related to laboratory testing and does not relieve me of any obligation to seek authorization for my services.

Account No.: _____

Provider Name (print): _____ NPI: _____

Provider Phone No.: _____ Fax No.: _____

_____ / _____
Ordering Provider Signature **Date**

Patient understands by signing below:
Labcorp may use information obtained on this form and other information provided by me and/or my ordering provider or their designee to initiate prior authorization with my health plan as required. I understand a prior authorization approval from my health plan does not guarantee full payment. It is my responsibility to contact my health plan regarding concerns over my coverage and benefits.

_____
Patient Signature

_____
Date

*Relationships to consider include parents, siblings, offspring (1st degree), half-brothers/sisters, aunts/uncles, grandparents, grandchildren, nieces/nephews (2nd degree).

Visit labcorp.com for detailed information on genes included in each panel.

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