

For test inquiries please call: 513-636-4530

Fax: 513-803-5056

Email: nephclinlab@cchmc.org

## DENSE DEPOSIT DISEASE AND C3 GLOMERULONEPHRITIS TEST REQUISITION

All Information Must Be Completed Before Sample Can Be Processed

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
*Last First MI*

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

MR# \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*(month) (day) (year)*

Gender:  Male  Female

### ETHNIC/RACIAL BACKGROUND (Choose All)

European American (White)  African-American (Black)

Native American or Alaskan  Asian-American

Pacific Islander

Ashkenazi Jewish ancestry

Latino-Hispanic \_\_\_\_\_  
*(specify country/region of origin)*

Other \_\_\_\_\_  
*(specify country/region of origin)*

### BILLING INFORMATION (Choose ONE method of payment)

#### REFERRING INSTITUTION

Institution: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Accounts Payable Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

#### COMMERCIAL INSURANCE\*

Insurance can only be billed if requested at the time of service.

Policy Holder Name: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*(month) (day) (year)*

Authorization Number: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_

Insurance Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_

#### \*PLEASE NOTE:

- We will not bill Medicaid or Medicaid HMO except for the following: CCHMC Patients, CCHMC Providers, or Designated Regional Counties.
- Commercial Insurance Precertification for genetic testing available upon request. Test(s) will not be started until authorization is obtained.
- If you have questions, please call 1-866-450-4198 for complete details.

### REFERRING PHYSICIAN

Physician Name (print): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_ Email: \_\_\_\_\_

Genetic Counselor/Lab Contact Name: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_ Email: \_\_\_\_\_

Referring Physician Signature (REQUIRED) \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*(month) (day) (year)*

Patient signed completed ABN for genetic testing

**Medical Necessity Regulations:** At the government's request, the Molecular Genetics Laboratories would like to remind all physicians that when ordering tests that will be paid under federal health care programs, including Medicare and Medicaid programs, that these programs will pay only for those tests the relevant program deems to be (1) included as covered services, (2) reasonable, (3) medically necessary for the treatment and diagnosis of the patient, and (4) not for screening purposes.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### CLINICAL AND LABORATORY INFORMATION (If Available)

Is the patient receiving plasma infusion or plasmapheresis?:  Yes  No

Creatinine: \_\_\_\_\_

If yes, date: \_\_\_\_\_

C3: \_\_\_\_\_ C4: \_\_\_\_\_

#### Proband Family

- |                          |                          |                      |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Renal disease        |
| <input type="checkbox"/> | <input type="checkbox"/> | Macular degeneration |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____         |

Has the patient had a kidney biopsy (Y/N)? \_\_\_\_\_

If so, what was the diagnosis? \_\_\_\_\_

### SAMPLE/SPECIMEN INFORMATION

Collection Date: \_\_\_\_\_

Has patient received a bone marrow transplant?  Yes  No

Time: \_\_\_\_\_

If yes, date of bone marrow transplant \_\_\_\_\_

Percent engraftment \_\_\_\_\_

Please send saliva kit and two cytobrushes.

Note: STR analysis at an additional charge is required on cytobrushes and saliva samples obtained on all patients post BMT.

### TEST(S) REQUESTED

Please see page 3 of requisition for sample requirements.

#### QUANTITATIVE COMPLEMENT TESTING

- Complete Complement Profile**  
(Includes C1q, C2, C3, C4, C5, C6, C7, C8, C9, Factor B, Factor I, Factor H, Factor D (coming soon), Properdin, C1 Inhibitor, and C4 Binding Protein)
- |                              |                                   |   |
|------------------------------|-----------------------------------|---|
| <input type="checkbox"/> C1q | <input type="checkbox"/> C7       | <input type="checkbox"/> Factor H               |
| <input type="checkbox"/> C2  | <input type="checkbox"/> C8       | <input type="checkbox"/> Factor D (coming soon) |
| <input type="checkbox"/> C3  | <input type="checkbox"/> C9       | <input type="checkbox"/> Properdin              |
| <input type="checkbox"/> C4  | <input type="checkbox"/> Factor B | <input type="checkbox"/> C1 Inhibitor           |
| <input type="checkbox"/> C5  | <input type="checkbox"/> Factor I | <input type="checkbox"/> C4 Binding Protein     |
| <input type="checkbox"/> C6  |                                   |   |

#### AUTOANTIBODY TESTING

- Factor H Autoantibody  
 C3 Nephritic Factor

#### FUNCTION/ACTIVATION TESTING

- |  |  |
|--|--|
| <input type="checkbox"/> C5 Functional | <input type="checkbox"/> C5a           |
| <input type="checkbox"/> Bb            | <input type="checkbox"/> sC5b-9 (sMAC) |
| <input type="checkbox"/> C3a           |  |

#### ANTI-C5 PHARMACOKINETIC PANEL

- Anti-C5 Pharmacokinetic Panel**  
(Includes anti-C5 (Eculizumab) level, C5, C5 functional, and CH50. For assessing complement activity to monitor patients on C5 inhibitor therapy.)
- |   |  |
|---|--|
| <input type="checkbox"/> Eculizumab Level | <input type="checkbox"/> C5            |
| <input type="checkbox"/> CH50             | <input type="checkbox"/> C5 Functional |

#### GENETIC TESTING

- Dense Deposit Disease/C3 Glomerulonephritis Sequencing Panel**  
(Includes *CFH*, *C3*, *CFB*, *CFHR5*, *CFI*, and *MCP*)  
**\*CCHMC Genetics staff — see below for additional details**
- Reflex to deletion/duplication of *C3*, *CFB*, and *CFI*
- Reflex to deletion/duplication of single gene(s)<sup>1</sup> (specify): \_\_\_\_\_
- <sup>1</sup>Deletion/Duplication analysis of *CFH*, *CFHR5*, or *MCP* is not available at this time.
- CFH* Custom Gene Sequencing
- C3* Custom Gene Sequencing  
 Reflex to deletion/duplication of *C3*
- CFB* Custom Gene Sequencing  
 Reflex to deletion/duplication of *CFB*
- CFHR5* Custom Gene Sequencing
- CFI* Custom Gene Sequencing  
 Reflex to deletion/duplication of *CFI*
- MCP* Custom Gene Sequencing
- Targeted (family specific) mutation analysis
- Gene of interest \_\_\_\_\_
- Proband's name \_\_\_\_\_
- Proband's DOB \_\_\_\_\_
- Proband's mutation \_\_\_\_\_

Please call 513-636-4474 to discuss any family-specific mutation analysis with genetic counselor prior to shipment.

### SHIPPING

Ship all samples frozen on dry ice to:  
CCHMC Division of Nephrology  
Clinical Laboratory, T.6-325 Dock 1  
240 Albert Sabin Way, Cincinnati Ohio 45229  
**MONDAY—FRIDAY DELIVERY ONLY\*\***

**Holiday and Weekend Shipping:**  
CCHMC Division of Nephrology  
3333 Burnet Avenue, Main Dock  
Attn: Storeroom BL1.300  
Cincinnati OH 45229

\*Dense Deposit Disease/C3 Glomerulonephritis Sequencing Panel should be accessioned with the aHUS Genetic Susceptibility Panel

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## DENSE DEPOSIT DISEASE AND C3 GLOMERULOPATHY TESTING INFORMATION SHEET

Test Name	Performing Lab	Specimen Requirements	TAT/ Days Performed	CPT Codes
<b>Quantitative Testing</b>				
Complete Complement Profile	Nephrology 513-636-4530	1 mL red top serum—spun, separated, frozen within 2 hrs of collection; ship on dry ice	1 week	86160 x15
Single complement component (C1q, C2, C3, C4, C5, C6, C7, C8, C9, Factor H, Factor I, Factor B, Factor D, C1 Inhibitor, C4 Binding Protein, Properdin)	Nephrology 513-636-4530	0.5 mL red top serum—spun, separated, frozen within 2 hrs of collection; ship on dry ice	1 week	86160
<b>Autoantibody Testing</b>				
Factor H Autoantibody	Nephrology 513-636-4530	0.5 mL red top serum—spun, separated, frozen within 2 hrs of collection; ship on dry ice	2–4 days Tues, Fri	83516
C3 Nephritic Factor	Nephrology 513-636-4530	1 mL red top serum—spun, separated, frozen within 2 hrs of collection; ship on dry ice	1–2 weeks	86160 x4
<b>Function/Activation Testing</b>				
C5 Functional	Nephrology 513-636-4530	0.5 mL red top serum—spun, separated, frozen within 2 hrs of collection; ship on dry ice	24 hrs Mon–Fri	86161
Bb	Nephrology 513-636-4530	0.5 mL EDTA plasma—spun, separated, frozen within 2 hrs of collection; ship on dry ice	1 week	86160
C3a	Cancer and Blood Disease Institute 513-803-3503	0.5 mL EDTA plasma—spun, separated, frozen within 2 hrs of collection, separate aliquot each test; ship on dry ice	2 weeks	86160
C5a	Cancer and Blood Disease Institute 513-803-3503	0.5 mL EDTA plasma—spun, separated, frozen within 2 hrs of collection, separate aliquot each test; ship on dry ice	2 weeks	86160
sC5b-9 (sMAC)	Cancer and Blood Disease Institute 513-803-3503	0.5 mL EDTA plasma—spun, separated, frozen within 2 hrs of collection, separate aliquot each test; ship on dry ice	1 week	86160
<b>Anti-C5 Therapeutic Monitoring</b>				
Anti-C5 Pharmacokinetic Panel (Includes Anti-C5 (Eculizumab) level, C5, C5 Functional, and CH50)	Nephrology 513-636-4530	1 mL red top serum—spun, separated in two 0.5 mL aliquots, frozen within 2 hrs of collection; ship on dry ice	2–4 days Mon–Fri	80299, 86161, 86162, 86160
Anti-C5 (Eculizumab) Level	Nephrology 513-636-4530	0.5 mL red top serum—spun, separated, frozen within 2 hrs of collection; ship on dry ice	2–4 days Mon–Fri	80299
C5 Functional	Nephrology 513-636-4530	0.5 mL red top serum—spun, separated, frozen within 2 hrs of collection; ship on dry ice	24 hrs Mon–Fri	86161
CH50	Nephrology 513-636-4530	0.5 mL red top serum—spun, separated, frozen within 2 hrs of collection; ship on dry ice	1–4 days Mon–Fri	86162
<b>Genetic Testing</b>				
Dense Deposit Disease/C3 Glomerulonephritis Sequencing Panel (CFH, C3, CFB, CFHR5, CFI, and MCP)	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature*	42 days	81479 x10
C3 Custom Gene Sequencing	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature*	90 days	81479
CFH Custom Gene Sequencing	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature*	90 days	81479
CFB Custom Gene Sequencing	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature*	90 days	81479
CFHR5 Custom Gene Sequencing	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature*	90 days	81479
CFI Custom Gene Sequencing	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature*	90 days	81479
MCP Custom Gene Sequencing	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature*	90 days	81479
Deletion/duplication analysis of C3, CFB, and/or CFI	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature* for each gene tested	90 days	81479 for each gene tested
Any single gene sequencing test	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature*	90 days	81479
Targeted mutation analysis	Molecular Genetics 513-636-4474	3 mL EDTA—whole blood, room temperature*	2 weeks	86160 x4

DO NOT FREEZE SAMPLES FOR GENETIC TESTING.

\*Call for other acceptable specimen types.