Cincinnati Children's

MOLECULAR GENETICS LABORATORY
For courier service and/or inquiries, please contact 513-636-4474 • Fax: 513-636-4373
www.cincinnatichildrens.org/moleculargenetics • Email: moleculargenetics@cchmc.org

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HEARING LOSS 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 _____ / _____ / _____

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)

☐ PATIENT BILLING

☐ Check Enclosed ☐ Money Order ☐ Credit Card (Visa, MC, Amex., Disc.)

Credit Card Number: _____

Card Holder Name: _____

Expiration Date: _____

Signature: _____

☐ REFERRING INSTITUTION

Institution: _____

Address: _____

City/State/Zip: _____

Accounts Payable Contact Name: _____

Phone: _____

Fax: _____

Email: _____

☐ COMMERCIAL INSURANCE / POLICY HOLDER INFORMATION*

Name: _____

Gender: _____ Date of Birth _____ / _____ / _____

Authorization Number: _____

Insurance Name: _____

Insurance Address: _____

City/State/Zip: _____

Insurance ID Number: _____

Group Number: _____

Insurance Phone Number: _____

* PLEASE NOTE:

- Insurance can only be billed if requested at the time of service
- Please call 866-450-4198 with any billing questions.

REFERRING PHYSICIAN

Physician Name (print): _____

Address: _____

Phone: (_____) _____ Fax: (_____) _____ Email: _____

Genetic Counselor/Lab Contact Name: _____

Phone: (_____) _____ Fax: (_____) _____ Email: _____

_____ Date: ____/ ____/ ____

Referring Physician Signature (REQUIRED)

☐ Patient signed completed ABN

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.

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Patient Name: _____ Date of Birth: _____

SAMPLE/SPECIMEN INFORMATION

Specimen Type:

☐ Amniotic fluid ☐ Blood ☐ Cord blood ☐ CVS ☐ Saliva

☐ 2 Cytobrushes (*GJB2, GJB6,* or mtDNA Panel only)

☐ 6 Cytobrushes (Tier 1, *EYA1,* and *SLC26A4* only)

Note: Cytobrush samples are not acceptable for any panel except Tier 1 and mtDNA Panel

☐ Other_____

Specimen Date: _____ / _____ / _____ Time: _____

Specimen Amount: _____

Each test requires 3 mL of whole blood in EDTA tube. Please call before sending alternate tissue samples, and for free cytobrush or saliva collection kits.

DRAWN BY: _____

*Phlebotomist must initial tube of specimen to confirm sample identity

TEST(S) REQUESTED

Hearing Loss Panels

☐ Hearing Loss Panel Tier I* (*GJB2, GJB6* and 8 mitochondrial mutations)

☐ OtoSeq® Hearing Loss Panel** (sequencing of 23 genes including *CDH23, CLRN1, EYA1, FOXI1, GJB2, GJB6, GPR98, KCNJ10, MYO6, MYO7A, OTOF, PCDH15, POU3F4, SIX1, SIX5, SLC26A4, TMC1, TMIE, TMPRSS3, USH1C, UHS1G, USH2A, WHRN)*

☐ Hearing Loss Panel Tier I* with reflex to OtoSeq® Hearing Loss Panel, if indicated

☐ Branchiootorenal Spectrum Disorder (BOR/BOS) Panel (sequencing of *EYA1, SIX1, SIX5)*

☐ Branchiootorenal Spectrum Disorder (BOR/BOS) Panel with reflex to OtoSeq® reanalysis, if indicated

☐ Hearing Loss mtDNA Panel (mtDNA 961, 1555, 1494, 3242, 3271, 7445, 7511, 8344)

☐ Pendred Syndrome Panel (*SLC26A4, FOXI1, KCNJ10*)

☐ Pendred Syndrome Panel with reflex to OtoSeq® reanalysis, if indicated

☐ Usher Syndrome Panel (sequencing of *CDH23, CLRN1, GPR98, MYO7A, PCDH15, USH1C, UHS1G, USH2A, WHRN)*

☐ Usher Syndrome Panel with reflex to OtoSeq® reanalysis, if indicated

Single Gene Tests

☐ *CDH23 (USH1D* and *DFNB12)*

☐ *EYA1* (branchiootorenal spectrum disorder type 1)

☐ *GJB2* (connexin 26)

☐ *GJB6* (connexin 30) deletion analysis

☐ *MYO7A* (USH1B, DFNB2, DFNA11)

☐ *OTOF* (AUNB1, DFNB9)

☐ *SLC26A4* (Pendred syndrome, DFNB4)

☐ **Targeted (family specific) mutation analysis**

Gene of interest _____

Proband's name _____

Proband's DOB _____

Proband's mutation _____

Relationship to proband _____

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

Either Hearing Loss Panel Tier 1 or OtoSeq® Hearing Loss Panel ** is indicated for patients with sensorineural hearing loss of unknown etiology who have had no previous genetic testing. OtoSeq® Hearing Loss Panel may also be used as follow-up testing in patients with normal *GJB2* or Hearing Loss Panel Tier 1 test results. Please see our website, www.cincinnatichildrens.org/hearing-loss, for complete information.

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Hearing Loss Testing Program
Required Clinical Information

TEST INDICATION:

☐ Diagnosis in symptomatic patient ☐ Family study (please attach proband's report)
☐ Prenatal testing (by previous arrangement only) ☐ Carrier testing

AUDIOLOGIC HISTORY: Audiogram (**MUST BE ATTACHED**)

CONGENITAL HEARING LOSS: ☐ Yes ☐ No

If **NOT** congenital, age at onset of hearing loss: _____

TYPE OF HEARING LOSS: ☐ sensorineural ☐ conductive ☐ mixed ☐ auditory neuropathy

PROGRESSION: ☐ stable ☐ progressive ☐ fluctuating ☐ unknown

VESTIBULAR PROBLEMS: ☐ none ☐ unknown ☐ delayed walking
☐ dizziness/vertigo ☐ balance abnormalities

RADIOLOGIC EVALUATION: (PLEASE ATTACH)

CT scan/MRI of temporal bones? ☐ Yes ☐ No ☐ Ordered
If Yes, Dilated vestibular aqueducts/EVA? ☐ Yes ☐ No
Mondini malformation/inner ear dysplasia? ☐ Yes ☐ No

SYNDROMIC ASSOCIATIONS:

BOR/BOS: ☐ none ☐ ear tags/pits ☐ ear abnormalities
☐ branchial clefts/cysts ☐ renal abnormalities

USHER: ☐ none ☐ retinitis pigmentosa if yes, age at diagnosis: _____

Other syndromic features or medical problems: _____

Aminoglycoside exposure ☐ Yes ☐ No

PREVIOUS GENETICS TESTING: ☐ Yes ☐ No

If Yes; specify gene and results including variants: _____

FAMILY HISTORY:

Relative(s) with hearing loss ☐ Yes ☐ No
If yes, please specify relationship to patient: _____

Parental consanguinity? ☐ Yes ☐ No

All information must be completed before testing will be undertaken