HEARING LOSS TEST REQUISITION FORM

MOLECULAR GENETICS LABORATORY
3333 Burnet Avenue, Room R1042
Cincinnati, OH 45229
Email: moleculargenetics@cchmc.org
www.cincinnatichildrens.com/moleculargenetics
(513) 636-4474 / Fax: (513) 636-4373

PATIENT INFORMATION

NAME:_____, _____, _____
Last First MI

ADDRESS: _____
_____

MR #_____ **GENDER**: M____ F ____

HOME PHONE: (_____)_____

DATE OF BIRTH ____/____/____
mm / dd / yy

ETHNICITY: ☐ African-American ☐ Asian
☐ Caucasian ☐ Hispanic
☐ Native American
☐ Other (Please specify) _____

SAMPLE INFORMATION

SPECIMEN TYPE:
☐ Blood (3 mL in EDTA tube for each test)
☐ Cytobrushes
☐ 2 cytobrushes (*GJB2*, *GJB6* or mitochondrial tests)
☐ 6 cytobrushes (tier 1 and Pendrin (*SLC26A4*)

Note: cytobrush samples are not acceptable for tier II, *MYO7A*, *CDH23* and *OTOF* tests).

☐ Amniotic Fluid ☐ CVS ☐ Cord Blood
Other (Specify): _____

SPECIMEN DRAW DATE: _____/_____/_____
Time: _____
SPECIMEN AMOUNT: _____
DRAWN BY: _____

***Phlebotomist must initial tube of specimen to confirm sample identity**

TEST REQUESTED (attach audiogram for all tests)

- ○ Hearing Loss Panel Tier I *
- ○ Hearing Loss Panel Tier II**

- OR -

- ○ GJB2 (connexin 26)
  - ☐ Full gene sequence analysis ☐ Known mutation detection*
- ○ GJB6 (connexin 30)
- ○ Mitochondrial mutation analysis 12SrRNA & $tRNA^{ser(UCN)}$
  - ☐ Full gene sequence analysis ☐ Known mutation detection*
- ○ Pendrin (SLC26A4)
  - ☐ Full gene sequence analysis ☐ Known mutation detection*
- ○ Cadherin (CDH23)
  - ☐ Full gene sequence analysis ☐ Known mutation detection*
- ○ Myosin 7A (MYO7A)
  - ☐ Full gene sequence analysis ☐ Known mutation detection*
- ○ Otoferlin (OTOF)
  - ☐ Full gene sequence analysis ☐ Known mutation detection*

* Family-specific mutation analysis (by prior arrangement only).

*__Tier I__ testing is indicated for patients with sensorineural hearing loss of unknown etiology who have had no previous molecular genetic studies. Tier I testing identifies the most common genetic causes of childhood sensorineural hearing loss and includes testing for mutations in *GJB2* and *GJB6*, as well as *the* specific mutations A1555G, C1494T, A7445G, and C7511T in the *12SrRNA* and $tRNA^{ser(UCN)}$ mitochondrial genes.

** **Tier II** testing is indicated for all patients with sensorineural hearing loss who have had a normal *GJB2* (connexin 26) or **Tier I** study previously. **Tier II** testing identifies mutations in the *OTOF*, *CDH23*, and *MYO7A* genes which cause hearing loss associated with auditory neuropathy (*OTOF*) and Usher syndrome type 1 (*CDH23* and *MYO7A*) as well as with nonsyndromic hearing loss.

Please visit our website at www.Cincinnatichildrens.org/molecular-genetics for complete information.

CLINICAL INFORMATION/TEST INDICATIONS

Test indications : ☐ Diagnosis (ICD9: 389.10) ☐ Carrier testing (ICD9: V80.3)

1) **Audiologic History:** Audiogram (**MUST BE ATTACHED**)
Congenital hearing Loss: Yes_____: No_____
If **NOT** congenital , date of onset of hearing loss:_____

2) **Radiologic Evaluation: (PLEASE ATTACH)**
CT scan/MRI of temporal bones? Yes_____: No_____: Ordered_____
If YES: Dilated vestibular aqueducts? Yes_____: No_____
Mondini malformation/inner ear dysplasia? Yes_____: No_____

3) **Syndromic Associations:**
Syndromic features or Name of syndrome (i.e. Pendred, BOR, Jervell and Lange-Nielsen): _____

****BOTH PAGES OF REQUISITION MUST BE COMPLETED BEFORE SAMPLE CAN BE PROCESSED****

HEARING LOSS TEST REQUISITION FORM (page 2)

Other relatives with hearing loss? Yes _____ No _____

If Yes, please specify relationship to patient:

_____

Inheritance: ____recessive ____dominant ____X-linked

____Mitochondrial

PEDIGREE OR SUMMARY OF FAMILY HISTORY

REFERRING PHYSICIAN/GENETIC COUNSELOR INFORMATION

Physician Name (print): _____

Phone: (_____) _____ Fax: (_____) _____Email: _____

Address: _____

_____

Genetic Counselor Name (print): _____

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

_____ _____

REFERRING PHYSICIAN SIGNATURE (REQUIRED) **DATE**

BILLING INFORMATION (complete or attach) **(CHOOSE ONE METHOD OF PAYMENT)**

1. ☐ Check enclosed ☐ Money Order ☐Credit Card (AMEX / MC / VISA / DISCOVER - Please Circle One)

Account #: _____ Exp date:_____

Cardholder name (print): _____

Cardholder signature: _____

2. ☐ Referring Institution or MD

Institution Name: _____ Financial Contact: _____

Billing Address: _____ Phone #: _____

_____ Fax #: _____

Email (required): _____

3. ☐ Insurance/Policyholder's Information

- HMO, PPO, Commercial Ins - provide front/back copy of insurance card.
- OH, IN, KY - all other states' Medicaid require letter of authorization

Name: _____ D.O.B. ____/____/____ SS#: _____-____-_____ Gender: M / F

Authorization #: _____ Relationship to Patient: _____

Insurance Name: _____ Insurance ID#: _____

Group #: _____

Insurance Address: _____

☐ **Check here if 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.

****ALL INFORMATION MUST BE COMPLETED BEFORE SAMPLE CAN BE PROCESSED****