

## HEARING LOSS TESTING 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)

#### 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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

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

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

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

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

**\* PLEASE NOTE:**

- We will not bill Medicaid, Medicaid HMO, or Medicare except for the following: CCHMC Patients, CCHMC Providers, or Designated Regional Counties.
- If you have questions, please call 1-866-450-4198 for complete details.

### SAMPLE/SPECIMEN INFORMATION

**SPECIMEN TYPE:**  Amniotic fluid  Blood  Cord blood  CVS

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

### 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.

**TEST(S) REQUESTED**

**AUDIOGRAM MUST BE ATTACHED. ATTACH CT/MRI IF AVAILABLE.**

**Please complete Required Clinical Information Sheet (page 4) prior to requisition submission.**

Please indicate if Audiogram or CT/MRI is unavailable:  Audiogram unavailable  CT/MRI unavailable

**Hearing Loss Panels**

- Hearing Loss Panel Tier I\* (*GJB2* sequencing, *GJB6* deletion analysis and 8 mitochondrial mutations)
  - Reflex to deletion/duplication of *GJB2*
- OtoSeq® Hearing Loss Panel\*\* (sequencing of 23 genes including *ADGRV1*, *CDH23*, *CLRN1*, *EYA1*, *FOX11*, *GJB2*, *GJB6*, *KCNJ10*, *MYO6*, *MYO7A*, *OTOF*, *PCDH15*, *POU3F4*, *SIX1*, *SIX5*, *SLC26A4*, *TMC1*, *TMIE*, *TMPRSS3*, *USH1C*, *USH1G*, *USH2A*, *WHRN*)
  - Reflex to deletion/duplication of entire panel<sup>†</sup>
  - Reflex to deletion/duplication of single gene(s)<sup>†</sup> (specify): \_\_\_\_\_
- 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*)
  - Reflex to deletion/duplication of entire panel
  - Reflex to deletion/duplication of single gene(s) (specify): \_\_\_\_\_
- 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 (*FOX11*, *KCNJ10*, *SLC26A4*)
  - Reflex to deletion/duplication of entire panel
  - Reflex to deletion/duplication of single gene(s) (specify): \_\_\_\_\_
- Pendred Syndrome Panel with reflex to OtoSeq® reanalysis, if indicated
- Usher Syndrome Panel (sequencing of *ADGRV1*, *CDH23*, *CLRN1*, *MYO7A*, *PCDH15*, *USH1C*, *USH1G*, *USH2A*, *WHRN*)
  - Reflex to deletion/duplication of entire panel<sup>†</sup>
  - Reflex to deletion/duplication of single gene(s)<sup>†</sup> (specify): \_\_\_\_\_
- Usher Syndrome Panel with reflex to OtoSeq® reanalysis, if indicated

**Single Gene Tests**

- CDH23* (*USH1D* and *DFNB12*)
  - Reflex to deletion/duplication of *CDH23* (*USH1D* and *DFNB12*)
- EYA1* (branchiootorenal spectrum disorder type 1)
  - Reflex to deletion/duplication of *EYA1*
- GJB2* (connexin 26)
  - Reflex to deletion/duplication of *GJB2*
- GJB6* (connexin 30) deletion analysis
- MYO7A* (*USH1B*, *DFNB2*, *DFNA11*)
  - Reflex to deletion/duplication of *MYO7A* (*USH1B*, *DFNB2*, *DFNA11*)
- OTOF* (*AUNB1*, *DFNB9*)
  - Reflex to deletion/duplication of *OTOF* (*AUNB1*, *DFNB9*)
- SLC26A4* (Pendred syndrome, *DFNB4*)
  - Reflex to deletion/duplication of *SLC26A4* (Pendred syndrome, *DFNB4*)
- Targeted (family specific) mutation analysis for \_\_\_\_\_ gene  
If testing was **not** performed at CCHMC, please include proband's report and at least 100ng of proband's DNA to use as a positive control.
- 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.**

\*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](http://www.cincinnatichildrens.org/hearing-loss), for complete information.

<sup>†</sup>Deletion/Duplication analysis of *WHRN* is not available at this time.

**TEST(S) REQUESTED, CONTINUED**

**CUSTOM GENE SEQUENCING**

Gene(s) to be sequenced (specify): \_\_\_\_\_

Only genes with clear published functional relationship to rare diseases are accepted.

Suspected syndrome/ condition: \_\_\_\_\_

Please choose one of the following:

- Full gene(s) sequencing
- Full gene(s) sequencing with reflex to deletion and duplication analysis, if indicated (**please see list of genes available for del/dup at [www.cincinnatichildrens.org/deldup](http://www.cincinnatichildrens.org/deldup)**)
- Familial mutation analysis

Proband's name: \_\_\_\_\_

Proband's DOB: \_\_\_\_\_

Proband's mutation: \_\_\_\_\_

Patient's relation to proband: \_\_\_\_\_

If testing was **not** performed at CCHMC, please include proband's report and at least 100ng of proband's DNA to use as a positive control.

**DELETION AND DUPLICATION ASSAY**

Gene(s) to be analyzed (specify): \_\_\_\_\_

Please see list of available genes at: [www.cincinnatichildrens.org/deldup](http://www.cincinnatichildrens.org/deldup)

Suspected syndrome/ condition: \_\_\_\_\_

Please choose one of the following:

- Deletion and duplication analysis of gene(s) specified above
- Deletion and duplication analysis of gene(s) specified above with reflex to sequencing, if indicated
- Analysis of gene(s) specified above from previously analyzed deletion and duplication
- Familial deletion analysis

Proband's name: \_\_\_\_\_

Proband's DOB: \_\_\_\_\_

Proband's mutation: \_\_\_\_\_

Patient's relation to proband: \_\_\_\_\_

If testing was **not** performed at CCHMC, please include proband's report and at least 100ng of proband's DNA to use as a positive control.

# 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

#### Pendred Syndrome:

- None
- Abnormal perchlorate test (>15%)
- Goiter
- Enlarged vestibular aqueduct (EVA)
- Cochlear hypoplasia (Mondini malformation/dysplasia)

#### Usher Syndrome:

- None
- Retinitis pigmentosa

If yes, age at diagnosis: \_\_\_\_\_

Other syndromic features or medical problems: \_\_\_\_\_

#### Aminoglycoside exposure:

- Yes
- No

#### Previous Genetic 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.**