Cincinnati Children's
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Genetics and Genomics Diagnostic Laboratory
For courier service and/or inquiries, please contact 513-636-4474 • Fax: 513-636-4373
www.cincinnatichildrens.org/moleculargenetics • Email: LabGeneticCounselors@cchmc.org

Mailing Address:
3333 Burnet Avenue, Room R1042
Cincinnati, OH 45229

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.

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Patient Name: _____ Date of Birth: _____

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, FOXI1, 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[1]
- ☐ Reflex to deletion/duplication of single gene(s)[1] (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, 3243, 3271, 7445, 7511, 8344)

☐ Pendred Syndrome Panel (*FOXI1, 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[1]
- ☐ Reflex to deletion/duplication of single gene(s)[1] (specify): _____

_____

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

Additional Gene Panels

☐ Stickler Syndrome Gene Panel (sequencing of 13 genes including *BMP4, COL11A1, COL11A2, COL2A1, COL9A1, COL9A2, COL9A3, GZF1, LOXL3, LRP2, PLOD3, SOX9, VCAN)*
- ☐ **Reflex to Whole Exome Sequencing[††]**

☐ Treacher Collins Syndrome and Mandibulofacial Dysostosis Gene Panel (sequencing of 10 genes including *DHODH, EDNRA, EFTUD2, POLR1A, POLR1B, POLR1C, POLR1D, SF3B4, TCOF1, TXNL4A)*
- ☐ **Reflex to Whole Exome Sequencing[††]**

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, for complete information.

[1]Deletion/Duplication analysis of *WHRN* is not available at this time.

[††]Whole exome sequencing (WES) orders require a signed WES Consent Form and completion of the WES Test Requisition. Also, inclusion of biological parental samples is strongly encouraged to assist with the analysis of WES and to increase test yield. Please visit our website at www.cincinnatichildrens.org/exome to obtain the required documents. WES testing will NOT be started until all forms are completed and received by the lab.

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Patient Name: _____ Date of Birth: _____

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)**

☐ 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

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.

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Patient Name: _____ Date of Birth: _____

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.