

<b>REQUIRED INFORMATION FOR REFERRING LABORATORY USE ONLY:</b>			<b>FOR MORL USE ONLY:</b>		
Requisition Date:		Completed by:		Accn#:	
Blood Specimen Collection Date:			MORL Case #:		
<b>Part A) Patient Information (Required)</b>			<b>Part A,) Patient Demographic Information (Required)</b>		
<b>Name:</b> _____ Last First <b>DOB:</b> ____/____/____ month day year <b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <b>MRN:</b> _____			<b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic <b>Race:</b> <input type="checkbox"/> Caucasian <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> More Than One Race _____		
- OR Place patient ID sticker here -			<b>Please note: We request extensive patient demographic and clinical information. This information is required as it is very valuable in the interpretation of your patient's results.</b> Please check this requisition form. Did you provide the following? <input type="checkbox"/> Patient date of birth and gender; <input type="checkbox"/> Patient ethnicity and race; <input type="checkbox"/> Patient's clinical and family history of hearing loss.		
<b>Part B) Reporting Information (Required)</b>			<b>Part C) Payment Information (Required)</b>		
Health Care Provider:			***The MORL will NOT submit to insurance.		
E-mail address:			Institutional billing or payment by credit card is accepted.		
NPI:			Billing Contact:		
Institution:			Institution:		
Street Address:			Street Address:		
City:		State:	City:		State:
Phone: ( )		FAX: ( )	Phone: ( )		FAX: ( )
If you or your patient would like to pay by credit card please contact Jori Hendon at 319-335-6653					
<b>Part D1) Panel Test Requested (please see page 2 for information required prior to performing this test)</b>					
<input type="checkbox"/> OtoSCOPE® panel <b>Clinical information is very valuable in the interpretation of results. If information is not provided we cannot provide a phenotype/genotype correlation.</b> <input type="checkbox"/> Usher panel					
<b>Part D2) A la carte Tests Requested – Do NOT freeze blood</b>					
<input type="checkbox"/> GJB2/GJB6 (Connexin 26/30)		<input type="checkbox"/> MTRNR1 – C1494T & A1555G mutations		<input type="checkbox"/> MTTL1-A3243G mutation	
<input type="checkbox"/> Gene Specific _____					
<input type="checkbox"/> Familial Testing		Gene: _____		Mutation: _____	
Relationship to previously tested individual (pedigree required): _____					

**CPT codes link: <https://morl.lab.uiowa.edu/testing-menu>**

**DISCLAIMER:**

This request to order molecular diagnostic tests from the MORL certifies to the MORL that the ordering physician has obtained informed consent from the patient as required by applicable state or federal laws for each test ordered, that the ordering physician has authorization from the patient permitting the MORL to report results for each test ordered to the ordering physician, and that the ordering physician assumes responsibility for providing the patient with all associated guidance and counseling regarding the test results.

**Please see page 3 for sample and shipping requirements**

Physician or genetics counselor should review information on page 4 of this requisition form with their patient/patient's family.

Physician should complete parts A, D, and E; Referring Lab should complete parts B and C. Effective 5/27/2016

**Please contact Amy Weaver at 319-335-6623 if you have any questions**

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

**Part E) Pertinent Clinical History and Findings (Required for ALL testing).**

**Pertinent Clinical History and Findings:** (check)

**Audiologic History**  
(Audiograms or ABRs from all affected individuals)

Congenital hearing loss:  Yes  No

If NOT congenital, date of onset of hearing loss: \_\_\_\_\_

**Inheritance Pattern**

Recessive  
 Dominant  
 X-linked  
 Other \_\_\_\_\_

**Onset of Hearing Loss**

Congenital  
 Early childhood  
 Late

**Degree of Hearing Loss**

Mild  
 Moderate  
 Severe  
 Profound  
 Symmetric  
 Asymmetric

**Type of Hearing Loss**

Conductive  
 Sensorineural  
 Syndromic  
 Nonsyndromic

**Family History**

Other persons with hearing loss (if yes you **MUST** attach a pedigree):  
 Yes  No

If yes, relationship to person named on this sheet  
 \_\_\_\_\_

**Family History Comments:**

**Pertinent Clinical History and Findings:** (check)

**Physical Examination**  
(provide clinic notes pertaining to hearing loss)

Excluding hearing loss, physical examination entirely normal:  
 Yes  No

If no, were features of syndromic hearing loss present?  
 Describe features or name syndrome: \_\_\_\_\_

\_\_\_\_\_

**Vision:**

Does your patient wear corrective lenses?  Yes  No

If yes, please provide diopter of vision correction:  
 Left: \_\_\_\_\_ / Right: \_\_\_\_\_

\_\_\_\_\_

**Motor Milestones:**

Delayed sitting:  Yes  No  
 If yes, approximate age patient sat: \_\_\_\_\_

Delayed walking:  Yes  No  
 If yes, approximate age patient walked: \_\_\_\_\_

\_\_\_\_\_

**Pendred Syndrome:**

If the patient has **Pendred Syndrome**, was perchlorate study done? (If yes, attach copy of report)  
 Yes  No

Is a goiter present?  
 Yes  No

**Radiologic Studies**

CT scan / MRI of temporal bones (If yes, a disk of the temporal bone images or copy of report **MUST** be provided):  
 Yes  No

Report read as Dilated Vestibular Aqueducts?  
 Yes  No

**OR** Mondini malformation?  
 Yes  No

**Comments:**

**PLEASE INCLUDE A PEDIGREE, AUDIOGRAMS, TEMPORAL BONE IMAGING STUDIES (if performed) & CLINIC NOTES REGARDING HEARING LOSS FOR ALL TESTING REQUESTS**

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## Molecular Otolaryngology & Renal Research Laboratories Sample Requirements

Please contact Amy Weaver at 319-335-6623 or [amy-weaver@uiowa.edu](mailto:amy-weaver@uiowa.edu) if you have any questions

<b>DNA Testing Sample requirement</b>	Lavender (EDTA) top tubes ( <i>for whole blood</i> )
<b>Minimum sample volume</b>	8-10 cc. whole blood (minimum amount of 3-4 cc. is accepted for children under age 4) (We are not responsible for broken tubes.) OR 10 µg DNA, minimum concentration 50ng/ul - (A260/A280 1.8-2) resuspended in 0.1mM EDTA (10mM Tris HCl, 0.1mM EDTA, pH 8, Teknova Cat# T0220)

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**Please note if you send less than the minimum volume/concentration of blood and/or DNA your request for testing will be rejected and a new sample will be required to perform the testing indicated on page 1 of this testing requisition form.**

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### Blood or DNA Shipping requirements:

Overnight delivery, Room temperature (**DO NOT FREEZE**)  
Delivery: Monday-Friday.  
Samples may be refrigerated if delivery is delayed.

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<b>Information to Include:</b>	<b>Testing will not be performed unless ALL of the following information is provided and the minimum sample requirement (found on page 3) is met.</b>
<b>Specimen information:</b>	Patient identifiers ( <b>full name, date of birth, sex and medical record number</b> ) Patient address, necessary for receipt and/or reporting results Pertinent history and clinical findings (found on page 2) Date of collection & Sample type Ordering physician
<b>Billing information:</b>	<b>We will <u>NOT</u> bill insurance, Medicare or patient directly. Institutional billing accepted. Visa and Master Card accepted. Personal checks <u>NOT</u> accepted.</b> <i>Please include contact information including phone &amp; fax number for billing questions.</i>
<b>Reporting Information:</b>	Because of confidentiality issues reports will only be released to the individuals indicated on the page 1 of the testing requisition form.

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### Ship all samples to:

Attn: Dr. Richard Smith  
Molecular Otolaryngology & Renal Research Laboratories  
The University of Iowa  
285 Newton Road, 5270 CBRB  
Iowa City, IA, 52242

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For more information about the tests we offer at the MORL please visit our website at:

<https://morl.lab.uiowa.edu>

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**IMPORTANT INFORMATION FOR PHYSICIAN OR GENETIC COUNSELOR:**

DNA tests may detect an abnormality. Detection methods are greater than 99% accurate. Many of these tests are new. The analysis and interpretation represents our best knowledge and understanding of the genetics of deafness.

There is a small possibility that a test may not work properly or an error may occur. You may be asked for an additional sample if it is felt that confirmatory testing is needed.

An error in diagnosis may occur if incorrect information is provided with the sample.

Hearing loss is a complex disorder and penetrance of a phenotype (the degree of hearing loss, for example) may be variable. Research to determine genotype-phenotype correlations is ongoing.

Unexpected test results may be detected. These results may occur with screening tests that evaluate many different genetic regions. From these tests, information may be learned about you, your child/children or your family that is not directly related to the clinical reason for ordering the test (secondary results). This information may provide data about the risk for a different genetic disease with symptoms that may or may not be currently evident.

A risk associated with this testing is that genetic testing has the potential to unintentionally reveal information regarding a child's paternity. Although the goal of this testing does not relate to paternity, during testing we may find genetic changes in both parents that may indicate possible non-paternity. In some cases non-paternity may be confused with genetic changes that arise spontaneously, called de novo mutations. We will not attempt to resolve or disclose issues of non-paternity during the course of this testing.

Because of the complexity of DNA testing, results should be discussed with a genetic counselor or physician.

We follow guidelines proposed by the American College of Medical Genetics and do not offer carrier testing for autosomal recessive deafness in minors.

**Note: Hearing loss is a very complex disorder. This complexity means that mutations in many different genes can lead to deafness. It is possible that no mutations will be detected in the mutation screens (the genes) you have requested.**

**If your patient is interested in joining research studies ongoing in the MORL laboratories to investigate other genetic causes of deafness please ask your patient to email Dr. Richard JH Smith ([richard-smith@uiowa.edu](mailto:richard-smith@uiowa.edu)), Carla Nishimura ([carla-nishimura@uiowa.edu](mailto:carla-nishimura@uiowa.edu)), or Amy Weaver ([amy-weaver@uiowa.edu](mailto:amy-weaver@uiowa.edu)).**