



Instructions: This form is intended to be completed by the ordering healthcare professional. The accurate interpretation and reporting of genetic results is contingent upon the reason for testing, clinical information, family history, and ancestry. To help provide the best possible service, supply the information requested below and **send this paperwork with the specimen or return by fax to Mayo Clinic Laboratories, Attn: Genetic Counselors at 507-284-1759. Phone: 800-533-1710 / International clients: 855-379-3115 or +1-507-284-9273, or email mliintl@mayo.edu.**

Patient Information (required)

Patient Name (Last, First Middle)		Birth Date (mm-dd-yyyy)	
Preferred Name		Medical Record Number (if Birth Date is not available)	
Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other, specify: _____		Legal/Administrative Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other, specify: _____	
Gender Identity (optional)		Pronouns (optional)	

Referring Healthcare Professional Information

Requesting Healthcare Professional Name (Last, First)	Phone	Fax*
Genetic Counselor Name (Last, First)	Phone	Fax*

*Fax number given must be from a fax machine that complies with applicable HIPAA regulations.

Reason for Testing

<p>_____</p> <p>_____</p>

Clinical Information

Age of onset: _____ Exposure to aminoglycoside antibiotics (eg, gentamicin, tobramycin, amikacin): Yes No Unknown

Temporal bone abnormalities: Yes No If "Yes," specify: _____

Type of hearing loss; check all that apply:

Sensorineural Conductive Auditory neuropathy/dyssynchrony Mixed Unknown

Stable Progressive Fluctuating

Bilateral Unilateral

Syndrome(s) suspected: Yes No If "Yes," specify: _____

Other clinical features; list all relevant clinical symptoms, attach clinic note:

Audiogram; describe results, attach audiogram:

Biological Family History

Are other biological relatives known to be affected? Yes No If "Yes," indicate biological relationship to patient: _____

Are other biological relatives known to be carriers? Yes No If "Yes," indicate biological relationship to patient: _____

Have other biological relatives had molecular genetic testing? Yes No If "Yes," complete the information below:

Gene: _____

Name of individual tested (Last, First Middle): _____

Birth date of individual tested (mm-dd-yyyy): _____

Detected gene variants identified: _____

Laboratory at which testing was performed: _____