Complete and print.

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MAYO CLINIC LABORATORIES

Molecular Genetics: Hereditary Hearing Loss Patient Information

Instructions: 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: +1-507-266-5700 or email MLIINT@mayo.edu**

Patient Information (required)

Patient Name (Last, First Middle)	Birth Date (mm-dd-yyyy)
Sex Assigned at Birth ☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose	Legal/Administrative Sex ☐ Male ☐ Female ☐ Nonbinary

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

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:

Family History

Pedigree; draw pedigree below or attach pedigree:

Pedigree Key
○ Female ● ■ Affected
☐ Male ◉ ⊡ Carrier

Paternal ancestry: Maternal ancestry: Consanguinity: ☐ Yes ☐ No

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

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

Have other 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):

Mutations/Variants:

Laboratory at which testing was performed:

Print