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, and family history. 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: Molecular Genetics Lab Genetic Counselors at 507-284-1759**.

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date *(mm-dd-yyyy)*

Sex Assigned at Birth	Legal/Administrative Sex
☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose	☐ Male ☐ Female ☐ Nonbinary

Referring Provider Information

Referring Provider 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:

Paternal ancestry ______________________ Maternal ancestry ______________________

Consanguinity ☐ Yes ☐ No

Pedigree Key

○ Female ● ■ Affected

☐ Male ⊙ ⊡ Carrier

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: ______________________________

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