sema4

123456-2-X

Please place green collection kit barcode here.

HEARING & VISION LOSS TEST REQUISITION

Phone: **800-298-6470** / Fax: 646-859-6870
Branford CT Lic#: CL-0830
Stamford CT Lic#: CL-1016

Please fill out all the highlighted fields. Failure to do so may result in delayed testing and delivery of results.

PATIENT INFORMATION

Sema4 will use this information to contact the patient via automatic email, SMS, and/or phone regarding payment, testing status, and online results access. By submitting this requisition, I confirm that I have obtained the patient's authorization to be contacted by Sema4 by these means (email address must be specific to patient listed on form).

PATIENT EMAIL ADDRESS RECOMMENDED	PATIENT MOBILE/PRIMARY NUMBER REQUIRED
LAST NAME REQUIRED	FIRST NAME REQUIRED MI
DATE OF BIRTH MM / DD / YYYY	SEX ASSIGNED AT BIRTH REQUIRED ☐ MALE ☐ FEMALE ☐ INTERSEX
CLIENT MRN	
ADDRESS REQUIRED	CITY / STATE / ZIP REQUIRED

BIOLOGICAL MOTHER LAST NAME	FIRST NAME	DATE OF BIRTH MM / DD / YYYY
BIOLOGICAL FATHER LAST NAME	FIRST NAME	DATE OF BIRTH MM / DD / YYYY

BILLING INFORMATION

Bill to: ☐ Insurance (Provide ICD10 in Indications for Testing) ☐ Client/Institution ☐ Self Pay/No Insurance

POLICYHOLDER LAST NAME REQUIRED	POLICYHOLDER FIRST NAME REQUIRED	POLICYHOLDER DOB MM / DD / YYYY
INSURANCE CARRIER REQUIRED	INSURANCE ID REQUIRED	GROUP NO. REQUIRED

BILLING ADDRESS REQUIRED

SECONDARY INSURANCE ☐ YES ☐ NO

SECONDARY INSURANCE NAME	GROUP NO.

Pre-Authorization #: _____ *Please include a copy of all insurance paperwork.*

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the provider and I understand that I am financially responsible for uncovered services. I also authorize the release of any information required to process the claim. Billing inquiries, please call 800-298-6470.

SIGNATURE DATE MM / DD / YYYY

ORDERING PROVIDER INFORMATION

NAME REQUIRED	GENETIC COUNSELOR
ADDRESS REQUIRED	CLINIC / INSTITUTION REQUIRED
	TELEPHONE
	FAX

PROVIDER SIGNATURE OF CONSENT (REQUIRED): I certify that this patient (and/or their legal guardian, as necessary) has been informed of the benefits, risks, and limitations of the laboratory test(s) requested. I have answered this person's questions. I have obtained a signed informed consent from this patient or their legal guardian for this testing in accordance with applicable laws and regulations, including N.Y. Civil Rights Law Section 79-L, and will retain this consent in the patient's medical record.

SIGNATURE DATE MM / DD / YYYY

CLINICAL INDICATION (PLEASE FILL OUT ADDITIONAL INDICATIONS ON BACK)

SPECIMEN TYPE:

Patient: ☐ Peripheral Blood ☐ Saliva ☐ Other:_____ Date of Collection: MM / DD / YYYY

Biological mother: ☐ Peripheral Blood ☐ Saliva ☐ Other:_____ Date of Collection:_____/_____/_____

Biological father: ☐ Peripheral Blood ☐ Saliva ☐ Other:_____ Date of Collection:_____/_____/_____

Parental samples will be used as needed in follow-up to patient testing

Please submit separate signed general consent form for each sample submitted (including parents)

For all prenatal specimens: please use Prenatal Requisition with supplemental Phenotype forms completed

PLEASE PROVIDE ICD10(s) HERE AND COMPLETE ALL CLINICAL QUESTIONS ON THE BACK PAGES* (REQUIRED)

☐ H90.5 (unspecified sensorineural hearing loss) ☐ H54.7 (unspecified visual loss)

☐ Other: _____

LABORATORY TEST(S) ORDERED

Test Selection (Required)

☐ **COMPREHENSIVE HEARING AND VISION LOSS PANEL (308 genes)** includes both Comprehensive Hearing Loss and Comprehensive Vision Loss Panels.
☐ **ADD-ON ULTRA-HIGH RESOLUTION HEARING AND VISION LOSS DEL/DUP ARRAY**

☐ **COMPREHENSIVE HEARING LOSS PANEL (92 genes)** includes *GJB2, GJB6, OTOA,* and *STRC* Del/Dup and Branchio-Oto-Renal Syndrome Panel, Usher Syndrome Panel, and Zellweger Syndrome Panel. The following 68 genes are in the Comprehensive Hearing Loss Panel but not in the subpanels:
☐*ACTG1,* ☐*AIFM1,* ☐*CACNA1D,* ☐*CCDC50,* ☐*CEACAM16,* ☐*CLDN14,* ☐*COCH,* ☐*COL11A2,* ☐*DFNA5,* ☐*DFNB59,* ☐*DIABLO,* ☐*DIAPH1,* ☐*EDN3,* ☐*EDNRB,* ☐*ESPN,* ☐*ESRRB,* ☐*EYA4,* ☐*GIPC3,* ☐*GPSM2,* ☐*GRHL2,* ☐*GRXCR1,* ☐*HGF,* ☐*ILDR1,* ☐*KARS,* ☐*KCNQ1,* ☐*KCNQ4,* ☐*LHFPL5,* ☐*LOXHD1,* ☐*LRTOMT,* ☐*MARVELD2,* ☐*MITF,* ☐*MSRB3,* ☐*MT-RNR1*(chrM:1494C>T & chrM:1555A>G only), ☐*MYH14,* ☐*MYH9,* ☐*MYO15A,* ☐*MYO3A,* ☐*MYO6,* ☐*OPA1,* ☐*OTOA* (CNV), ☐*OTOA* (NGS), ☐*OTOF,* ☐*OTOG,* ☐*OTOGL,* ☐*P2RX2,* ☐*PAX3,* ☐*PHYH,* ☐*POU3F4,* ☐*POU4F3,* ☐*PRPS1,* ☐*PTPRQ,* ☐*RDX,* ☐*SERPINB6,* ☐*SLC26A4,* ☐*SMPX,* ☐*SOX10,* ☐*STRC* (CNV), ☐*TBC1D24,* ☐*TECTA,* ☐*TIMM8A,* ☐*TMC1,* ☐*TMEM126A,* ☐*TMIE,* ☐*TMPRSS3,* ☐*TPRN,* ☐*TRIOBP,* ☐*TSPEAR,* ☐*WFS1*
☐**ADD-ON ULTRA-HIGH RESOLUTION HEARING LOSS DEL/DUP ARRAY**

☐**DFNB1-RELATED HEARING LOSS PANEL (2 genes)** includes ☐ *GJB2* (NGS) and ☐ *GJB2/GJB6* (CNV)

☐**BRANCHIO-OTO-RENAL SYNDROME PANEL (3 genes)** includes ☐*EYA1,* ☐*SIX1,* ☐*SIX5*
☐**ADD-ON ULTRA-HIGH RESOLUTION HEARING LOSS DEL/DUP ARRAY**

☐**USHER SYNDROME PANEL (11 genes)** includes ☐*ADGRV1,* ☐*CDH23,* ☐*CIB2,* ☐*CLRN1,* ☐*HARS,* ☐*MYO7A,* ☐*PCDH15,* ☐*USH1C,* ☐*USH1G,* ☐*USH2A,* ☐*WHRN*
☐**ADD-ON ULTRA-HIGH RESOLUTION HEARING LOSS DEL/DUP ARRAY**

☐**ZELLWEGER SYNDROME PANEL (9 genes)** includes ☐*PEX1,* ☐*PEX10,* ☐*PEX14,* ☐*PEX16,* ☐*PEX19,* ☐*PEX2,* ☐*PEX5,* ☐*PEX6,* ☐*PEX7*
☐**ADD-ON ULTRA-HIGH RESOLUTION HEARING LOSS DEL/DUP ARRAY**

☐ **COMPREHENSIVE VISION LOSS PANEL (250 genes)** includes Albinism, Hermansky-Pudlak Syndrome & Waardenburg Syndrome Panel, Developmental Eye Panel, Retinal Disease Panel, and Stickler & Cataract Panel. The following 33 genes are in the Comprehensive Vision Loss Panel but not in the subpanels: ☐*CABP4,* ☐*CDH3,* ☐*CLN3,* ☐*CLN5,* ☐*CLN6,* ☐*CLN8,* ☐*CTSD,* ☐*CYP1B1,* ☐*DNAJC5,* ☐*EFEMP1,* ☐*ELOVL4,* ☐*FRMD7,* ☐*FZD4,* ☐*GNAT1,* ☐*HESX1,* ☐*LYST,* ☐*MFSD8,* ☐*MTTP,* ☐*MYOC,* ☐*NYX,* ☐*PGK1,* ☐*PITX2,* ☐*PPT1,* ☐*RGS9,* ☐*RGS9BP,* ☐*RS1,* ☐*TGFBI,* ☐*TIMM8A,* ☐*TIMP3,* ☐*TPP1,* ☐*TREX1,* ☐*TSPAN12,* ☐*UBIAD1*
☐**ADD-ON ULTRA-HIGH RESOLUTION VISION LOSS DEL/DUP ARRAY**

☐**ALBINISM, HERMANSKY-PUDLAK SYNDROME, & WAARDENBURG SYNDROME PANEL (18 genes)** includes ☐*AP3B1,* ☐*BLOC1S6,* ☐*CACNA1F,* ☐*EDN3,* ☐*EDNRB,* ☐*GPR143,* ☐*HPS1,* ☐*HPS3,* ☐*HPS4,* ☐*HPS5,* ☐*HPS6,* ☐*MITF,* ☐*OCA2,* ☐*PAX3,* ☐*SLC45A2,* ☐*SOX10,* ☐*TYR,* ☐*TYRP1*
☐**ADD-ON ULTRA-HIGH RESOLUTION VISION LOSS DEL/DUP ARRAY**

☐**DEVELOPMENTAL EYE PANEL (21 genes)** includes ☐*BCOR,* ☐*BMP4,* ☐*FOXC1,* ☐*FOXE3,* ☐*FRAS1,* ☐*FREM1,* ☐*FREM2,* ☐*GRIP1,* ☐*HCCS,* ☐*KIF11,* ☐*MFRP,* ☐*NDP,* ☐*OTX2,* ☐*PAX6,* ☐*PITX3,* ☐*PLA2G5,* ☐*PXDN,* ☐*SMOC1,* ☐*SOX2,* ☐*STRA6,* ☐*VSX2*
☐**ADD-ON ULTRA-HIGH RESOLUTION VISION LOSS DEL/DUP ARRAY**

☐**RETINAL DISEASE PANEL (154 genes)** includes ☐*ABCA4,* ☐*ABHD12,* ☐*ADAM9,* ☐*ADGRV1,* ☐*AHI1,* ☐*AIPL1,* ☐*ALMS1,* ☐*ARL13B,* ☐*ARL6,* ☐*BBS1,* ☐*BBS10,* ☐*BBS12,* ☐*BBS2,* ☐*BBS4,* ☐*BBS5,* ☐*BBS7,* ☐*BBS9,* ☐*BEST1,* ☐*C2ORF71,* ☐*C5ORF42,* ☐*C8ORF37,* ☐*CA4,* ☐*CACNA1F,* ☐*CACNA2D4,* ☐*CAPN5,* ☐*CC2D2A,* ☐*CDH23,* ☐*CDHR1,* ☐*CEP164,* ☐*CEP290,* ☐*CEP41,* ☐*CERKL,* ☐*CHM,* ☐*CIB2,* ☐*CLRN1,* ☐*CNGA1,* ☐*CNGA3,* ☐*CNGB1,* ☐*CNGB3,* ☐*CNNM4,* ☐*CRB1,* ☐*CRX,* ☐*CYP4V2,* ☐*DHDDS,* ☐*EYS,* ☐*FAM161A,* ☐*FLVCR1,* ☐*FSCN2,* ☐*GNAT2,* ☐*GPR179,* ☐*GRK1,* ☐*GRM6,* ☐*GUCA1A,* ☐*GUCA1B,* ☐*GUCY2D,* ☐*HARS,* ☐*IFT140,* ☐*IMPDH1,* ☐*IMPG2,* ☐*INPP5E,* ☐*IQCB1,* ☐*KCNJ13,* ☐*KCNV2,* ☐*KIF7,* ☐*KLHL7,* ☐*LCA5,* ☐*LRAT,* ☐*LRIT3,* ☐*LZTFL1,* ☐*MAK,* ☐*MERTK,* ☐*MFRP,* ☐*MKKS,* ☐*MKS1,* ☐*MYO7A,* ☐*NMNAT1,* ☐*NPHP1,* ☐*NPHP3,* ☐*NPHP4,* ☐*NR2E3,* ☐*NRL,* ☐*OFD1,* ☐*OPA1,* ☐*OPN1SW,* ☐*PANK2,* ☐*PCDH15,* ☐*PDE6A,* ☐*PDE6B,* ☐*PDE6C,* ☐*PDE6G,* ☐*PDE6H,* ☐*PEX1,* ☐*PEX10,* ☐*PEX14,* ☐*PEX16,* ☐*PEX19,* ☐*PEX2,* ☐*PEX5,* ☐*PEX6,* ☐*PHYH,* ☐*PITPNM3,* ☐*PRCD,* ☐*PROM1,* ☐*PRPF3,* ☐*PRPF31,* ☐*PRPF6,* ☐*PRPF8,* ☐*PRPH2,* ☐*PRPS1,* ☐*RAB28,* ☐*RAX2,* ☐*RBP3,* ☐*RBP4,* ☐*RD3,* ☐*RDH12,* ☐*RDH5,* ☐*RGR,* ☐*RHO,* ☐*RIMS1,* ☐*RLBP1,* ☐*ROM1,* ☐*RP1,* ☐*RP1L1,* ☐*RP2,* ☐*RPE65,* ☐*RPGR,* ☐*RPGRIP1,* ☐*RPGRIP1L,* ☐*SAG,* ☐*SDCCAG8,* ☐*SEMA4A,* ☐*SLC24A1,* ☐*SNRNP200,* ☐*SPATA7,* ☐*TCTN1,* ☐*TCTN2,* ☐*TCTN3,* ☐*TMEM126A,* ☐*TMEM216,* ☐*TMEM231,* ☐*TMEM237,* ☐*TMEM67,* ☐*TOPORS,* ☐*TRIM32,* ☐*TRPM1,* ☐*TTC21B,* ☐*TTC8,* ☐*TULP1,* ☐*USH1C,* ☐*USH1G,* ☐*USH2A,* ☐*WDR19,* ☐*WHRN,* ☐*ZNF423*
☐**ADD-ON ULTRA-HIGH RESOLUTION VISION LOSS DEL/DUP ARRAY**

☐**STICKLER & CATARACT PANEL (41 genes)** includes ☐*ABHD12,* ☐*AGK,* ☐*BCOR,* ☐*BEST1,* ☐*CAPN5,* ☐*COL11A1,* ☐*COL11A2,* ☐*COL2A1,* ☐*COL9A1,* ☐*COL9A2,* ☐*CRX,* ☐*CRYAA,* ☐*CRYAB,* ☐*CRYBB1,* ☐*CRYBB3,* ☐*ERCC6,* ☐*EYA1,* ☐*FYCO1,* ☐*GCNT2,* ☐*GJA8,* ☐*GNPTG,* ☐*HSF4,* ☐*JAG1,* ☐*KCNJ13,* ☐*LRP5,* ☐*MYH9,* ☐*NDP,* ☐*OAT,* ☐*OPA3,* ☐*OTX2,* ☐*PAX6,* ☐*PEX16,* ☐*PEX7,* ☐*PHYH,* ☐*PITX3,* ☐*PXDN,* ☐*RLBP1,* ☐*TDRD7,* ☐*VCAN,* ☐*VSX2,* ☐*WFS1*
☐**ADD-ON ULTRA-HIGH RESOLUTION VISION LOSS DEL/DUP ARRAY**

COMPLETE AND SUBMIT ALL PAGES TO LABORATORY

HEARING LOSS CLINICAL INDICATIONS

AGE OF HEARING LOSS:

LATERALITY: ☐ Bilateral ☐ Unilateral

TYPE OF HEARING LOSS:
☐ Sensorineural ☐ Conductive ☐ Mixed
☐ Auditory neuropathy/dys-synchrony

PROGRESSION:
☐ Stable ☐ Progressive
☐ Fluctuating ☐ Unknown

SEVERITY (PTA): *Please attach audiogram if available.*

Left Ear: ☐ Mild (15-30dB) ☐ Moderate (31-50dB) ☐ Moderately-severe (51-70db) ☐ Severe (71-90db) ☐ Profound (>90dB)

Right Ear: ☐ Mild (15-30dB) ☐ Moderate (31-50dB) ☐ Moderately-severe (51-70db) ☐ Severe (71-90db) ☐ Profound (>90dB)

VISION LOSS CLINICAL INDICATIONS

AGE OF VISION LOSS:

LATERALITY: ☐ Bilateral ☐ Unilateral

TYPE OF VISION LOSS/SUSPECTED DIAGNOSIS:

PHENOTYPE (TO BE COMPLETED BY PHYSICIAN)

☐ Abnormal ERG	HP:0000512	☐ Intellectual disability	HP:0001249
☐ Absent ABR w/ cochlear microphonic	HP:0004463	☐ Keratoconus	HP:0000563
☐ Achromatopsia	HP:0011516	☐ Long QT	HP:0001657
☐ Aniridia	HP:0000526	☐ Macular degeneration	HP:0000608
☐ Balance problems	HP:0002141	☐ Mondini dysplasia	HP:0000376
☐ Branchial arch abnormality	HP:0009794	☐ Night Blindness	HP:0007642
☐ Cataracts	HP:0000518	☐ Nystagmus	HP:0000639
☐ Coloboma	HP:0000612	☐ Photophobia	HP:0000613
☐ Color blindness	HP:0007641	☐ Present OAEs	
☐ Cystoid macular edema	HP:0011505	☐ Renal abnormality	HP:0000077
☐ Delayed pupillary response	HP:0030211	☐ Retinal Detachment	HP:0000541
☐ Delayed walking	HP:0002194	☐ Retinitis pigmentosa	HP:0000510
☐ Dizziness/vertigo	HP:0002321	☐ Robin Sequence	HP:0000201
☐ Ear abnormalities	HP:0000377	☐ Skeletal abnormality	HP:0000924
☐ Ear tags	HP:0000384	☐ SNHL	HP:0000407
☐ EVA	HP:0011387	☐ Stapes fixation	HP:0000381
☐ Glaucoma	HP:0000501	☐ Tunnel vision	HP:0007994
☐ Heterochromia	HP:0001100	☐ Vivid blue eyes	HP:0000635
☐ Hirschprung	HP:0002251	☐ White forelock	HP:0002211

PEDIGREE AND ADDITIONAL NOTES

COMPLETE AND SUBMIT ALL PAGES TO LABORATORY

Informed Consent for Genetic Testing

If you do not have legal authority and capacity to sign this consent under law, a legal representative who is at least eighteen (18) years of age and has the legal authority and capacity to do so must sign this consent and authorization on your behalf.

I hereby request the genetic testing ordered by my health care provider, which may include molecular, cytogenetic, and/or biochemical analyses of my sample(s). I have received information (please see www.sema4.com/testcatalog for test-specific information sheet) from my physician or from a genetic counselor that described, in words that I understand, the nature of the genetic testing that I am about to undergo.

I understand that specimen(s), such as a peripheral blood, saliva, cheek swab, dried blood spot, skin biopsy, amniotic fluid, chorionic villus, and/or urine sample, will be taken from me. I understand that these samples will be used for determining if I have a genetic disease, am a carrier of a genetic disease, or am more likely to develop a genetic disease or condition.

The nature of the genetic test(s) ordered in connection with this consent has been explained to me, and the accuracy of the test and its risks and limitations have been detailed. I understand that infrequent errors may occur, even though the likelihood of an incorrect diagnosis or a misinterpretation of the result is extremely small. I understand that a negative result reduces, but does not eliminate, the possibility that I carry a variant(s) in the gene(s) analyzed or in other genes that are not included in the test. I understand that a positive result is an indication that I may be predisposed to or have a specific disease or condition and I may consider further independent testing, consult my physician or pursue genetic counseling. Knowledge of genetic information will improve over time and new information may become available in the future that could impact the interpretation of my results.

I understand that test results may reveal incidental, unsought information, such as discovering an undiagnosed disorder. I understand that this testing may yield results that are of unknown clinical significance and that parental or other relative's specimens may also be tested to determine whether a specific finding was inherited. This testing may reveal cases of adoption or demonstrate that a person is not the biological father or mother of the patient. An error in the diagnosis may occur if the true biological relationships of the family members involved are not as I have described.

I understand that the results of this testing will become part of my medical record and may only be disclosed to individuals who have legal access to this record or to individuals I designate to receive this information. My test results will be explained to me by a genetic counselor or by my healthcare provider, who will have the opportunity to discuss my results with a geneticist.

There are federal and state laws that address genetic discrimination. The US Genetic Information Nondiscrimination Act may prohibit discrimination based on genetic information by employers and health insurers. This law, however, does not protect people in the military nor protect against discrimination by other types of insurance, such as life, disability, or long-term care insurance.

Sample management

Sema4 may deidentify and retain your left-over sample to use for operational, quality control, validation and improvement purposes. Other than retention for these uses, your sample will be destroyed at the end of the testing process or within 60 days of sample collection, whichever is longer.

De-identified research

Sema4 may de-identify and use all data and information generated and received in connection with this test to support medical and academic research relating to health, disease prevention, drug development, and other scientific purposes. I will receive no compensation in connection with such research. Data and information are "de-identified" by removing any information that could be used to identify a specific person, such as a name, email address, or date of birth. Sema4 may also give the de-identified data and information to its research partners and may submit it to research databases for use in scientific and medical research. Examples of such research include projects to understand the risk factors and outcomes for various conditions and can be found at www.sema4.com/research.

If I do not want to have my de-identified data and information used in research as set forth above, I may withdraw this consent by emailing privacy@sema4.com, and I understand that the change will apply to all data generated from tests that I have undergone with Sema4. I further understand that this withdrawal will not apply to any information that has already been de-identified and cannot be identified by Sema4.

Permission to contact

I understand that Sema4 may wish to contact me in the future, including for the following reasons: research purposes, the provision of general information about research findings, and/or the provision of information about the results of tests on my sample(s). If I wish to opt-out out of future contact for research purposes, I will notify Sema4 by emailing privacy@sema4.com.

My healthcare provider has discussed my test order(s) with me, and I hereby consent to have my specimen tested. I have been encouraged to ask questions and agree that any questions I have asked have been answered to my satisfaction. If my legal representative is signing this consent and authorization, my legal representative is satisfied that they have received enough information to sign on my behalf.

Please complete all required (*) fields and optional applicable fields below:

Patient Name*	Patient's DOB*	Date*
Signature of Patient or Legal Representative*	Email Address*	Phone Number*
Legal Representative Name (if applicable)		

P0122GE0122
Revised 01/31/22