# HEARING & VISION LOSS TEST REQUISITION

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

123456-2-X

Please place green collection kit barcode here.

**Please be sure to fill out all highlighted fields. Failure to fill them in 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 | BIOLOGICAL SEX ☐ M ☐ F REQUIRED | PATIENT IS A SPERM/EGG DONOR ☐ YES ☐ NO |
| PARTNER / SPOUSE LAST NAME | PARTNER / SPOUSE FIRST NAME | |
| CLIENT MRN | PARTNER / SPOUSE DATE OF BIRTH MM / DD / YYYY | |
| ADDRESS REQUIRED | CITY / STATE / ZIP REQUIRED | |

## BILLING INFORMATION

Bill to: ☐ Client/Institution ☐ Insurance ☐ 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

## REFERRING 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 / YYY

## CLINICAL INDICATIONS*

SPECIMEN TYPE
☐ Blood ☐ Saliva ☐ Amniotic Fluid
☐ CVS ☐ Other _____
☐ Cultured Cells Type _____

Date/Time Specimen Drawn MM / DD / YYYY ____:____ AM PM

Date Specimen Sent MM / DD / YYYY

CLINICAL STATUS
☐ Affected ☐ Unknown (no screening/evaluation)
☐ Unaffected (all screening/evaluations(s) normal)

PURPOSE OF STUDY
☐ Diagnostic ☐ Carrier Testing
☐ Familial Follow-Up (Family Variant _____)
☐ Other: _____

***PLEASE SUBMIT PEDIGREE IF AVAILABLE (SPACE ON BACK)***

| | |
|---|---|
| PATERNAL ANCESTRY: | MATERNAL ANCESTRY: |

CONSANGUINITY? ☐ Yes ☐ No

***PLEASE COMPLETE ALL CLINICAL QUESTIONS ON THE BACK PAGE***

**ICD10 Dx CODE(S)**

☐ 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,* ☐*C20RF71,* ☐*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

I, _____, hereby request genetic testing, which may include molecular, cytogenetic and/or biochemical analyses, for

☐ Myself

☐ My child _____

I have received verbal and written information (please see sema4.com/testcatalog for test-specific information sheet) from my physician or from a genetic counselor that described, in words that I understood, the nature of the genetic testing that I/my child 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 villi and/or urine sample, will be taken from me/my child. I understand that the samples will be used for determining if I/my child have a genetic disease, are carriers of a genetic disease, or are more likely to develop a genetic disease or condition.

The nature of the genetic test(s) that have been 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. The likelihood of this occurring has been estimated to be less than 1%. I understand that a negative result reduces, but does not eliminate, the possibility that I/my child carry a mutation(s) in the gene(s) analyzed or in other gene(s) that are not included in the test.

I understand that no test will be performed on my sample other than the one(s) authorized by me and my healthcare provider. I have reviewed the test order made in connection with this consent, and I hereby give consent to have my specimen tested as set forth in the order.

**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, and 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, including scientific databases that are maintained by the federal government, such as a database kept by the National Institutes of Health ("NIH") (an agency of the federal government that funds research). Researchers have to apply to the NIH to see the information in the database. If I do not want to have any of my de-identified data and information used in research consistent with this consent, I may initial here_____, or I may withdraw this consent by contacting Sema4, including by emailing privacy@sema4.com.

**Permission to contact**

I understand that Sema4 may wish to contact me/my child 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/my child's sample(s). I understand that I may notify Sema4 to opt out of such future contact, including by emailing privacy@sema4.com.

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. In addition, incidental findings that are not related to the primary diagnosis may be identified in me/my child. An error in the diagnosis may occur if the true biological relationships of the family members involved are not as I have stated and this test may detect non-paternity.

The results of my/my child's test will be explained to me by a genetic counselor or by my physician who will have the opportunity to discuss my results with a geneticist. I have had the opportunity to have all of my questions answered. If I am signing this form on behalf of a minor for whom I am the legal guardian, I am satisfied that I have received enough information to sign on his or her behalf.

I understand that this consent is being obtained in order to protect my right to have all of my questions answered before testing. 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 who I designate to receive this information.

_____ _____

Signature of person being tested (or guardian) Date

FFP0122GE0121

Revised 01/20/2021

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