



Risk Factor Screening for Permanent Hearing Loss (PHL)
Request for Testing for Cytomegalovirus (CMV) and/or Genetic Risk Factors (GJB2/6, SLC26A4)

Patient Information	
Last name: _____ First name: _____ Date of birth (yyyy/mm/dd): _____ Health card number: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Ambiguous Mother's Name: _____	Address: _____ City: _____ Province: _____ Postal Code: _____ Country: _____
Ordering Doctor's Information	
Name: _____	Provider Number: _____
Hospital/Clinic and Department: _____	Phone: _____ Email: _____ Fax: _____
Clinical Indication	
<input type="checkbox"/> Confirmed PHL (SNHL) <input type="checkbox"/> Suspected congenital CMV <input type="checkbox"/> Confirmed diagnosis of congenital CMV <input type="checkbox"/> Confirmed CMV and suspected congenital infection <input type="checkbox"/> Family history of genetic risk factors for PHL <input type="checkbox"/> Negative urine CMV PCR (PHO only)	Additional clinical information: _____
Test Request	
<input type="checkbox"/> Cytomegalovirus qPCR ____ Initial to confirm that the parent or guardian consents to the use of the residual sample for this purpose.	
<input type="checkbox"/> Carrier disclosure for GJB2/6 and SLC26A4 genes and reflexive full gene sequencing of the respective gene if a single pathogenic variant was identified on the NSO common variant panel used for Risk Factor Screening ____ Initial to confirm that the parent or guardian consents to the disclosure of carrier status and subsequent full gene sequencing using the residual dried blood spot sample if a single pathogenic variant was identified through screening. <i>*Note. Carrier disclosure and possible full gene sequencing are only available to infants for whom Risk Factor Screening for PHL was performed in Ontario. Diagnostic genetic testing should continue to be ordered through the Genome Diagnostics Laboratory at the Hospital for Sick Children.</i>	
Specimen Details	
<i>Requests with accompanying samples only (e.g. from outside of Ontario, from Public Health Ontario (PHO))</i>	
Specimen Type: <input type="checkbox"/> Residual dried blood spot Date of Collection (YYYY/MM/DD) _____ Time of Collection (24HR): _____ PHO only: <input type="checkbox"/> Urine <input type="checkbox"/> Urine DNA <input type="checkbox"/> Urine culture DNA Date of Collection (YYYY/MM/DD) _____ Time of Collection (24HR) _____	Ship specimen, requisition, and billing form (if applicable) to: NSO Specimen Hub, 415 Smyth Road, Ottawa, ON, K1H 8M8

Please submit requisition to NSO by fax to 613-738-4214