How to order the Non-syndromic hearing loss panel

In order to request this test, you will need to:

1. Print and fill a **molecular genetics requisition** for your patient **AND** for the parents of your patient if the test is requested in Trio or Duo (see pages 3-7).
2. Print and fill an **eligibility criteria form** for your patient (see pages 8-11).
3. Forward the samples, the filled molecular genetics requisitions and the filled eligibility criteria form to the core molecular diagnostic laboratory (CMDL) of the MUHC (see page 12).

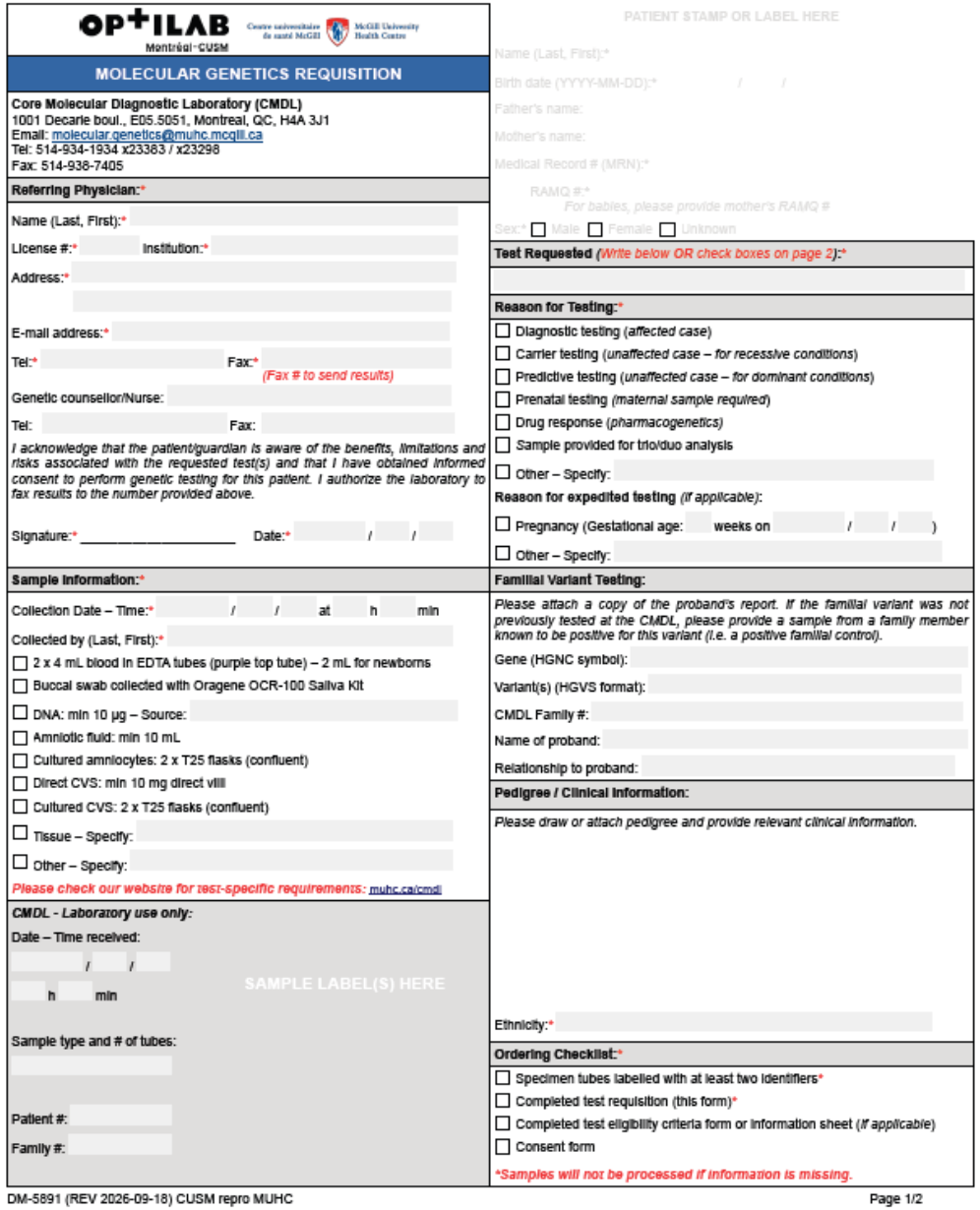
We strongly encourage all test to be requested in Trio (preferably) or in Duo.

A Trio analysis involves providing a sample for both biological parents of your patient, in addition to their sample.

A Duo analysis involves providing a sample for one biological parent of your patient, in addition to their sample.

Molecular Genetics Requisition

1. See here the molecular genetics requistion you can find at the following link (https://muhc.ca/sites/default/files/docs/m-Labs/Requisition_CMDL_MolGen_EN_2026-09.pdf). You will need to fill this requisition.



OPTILAB Montréal-CUSM — Centre universitaire de santé McGill — McGill University Health Centre

MOLECULAR GENETICS REQUISITION

Core Molecular Diagnostic Laboratory (CMDL)
1001 Decarie boul., E05.5051, Montreal, QC, H4A 3J1
Email: molecular.genetics@muhc.mcgill.ca
Tel: 514-934-1934 x23383 / x23398
Fax: 514-938-7405

Referring Physician:*

Name (Last, First):*
License #:* Institution:*
Address:*
E-mail address:*
Tel:* Fax:*
(Fax # to send results)
Genetic counsellor/Nurse:
Tel: Fax:

I acknowledge that the patient/guardian is aware of the benefits, limitations and risks associated with the requested test(s) and that I have obtained informed consent to perform genetic testing for this patient. I authorize the laboratory to fax results to the number provided above.

Signature:* _____ Date:* / /

Sample Information:*

Collection Date – Time:* / / at h min
Collected by (Last, First):*
☐ 2 x 4 mL blood in EDTA tubes (purple top tube) – 2 mL for newborns
☐ Buccal swab collected with Oragene OCR-100 Saliva Kit
☐ DNA: min 10 µg – Source:
☐ Amniotic fluid: min 10 mL
☐ Cultured amniocytes: 2 x T25 flasks (confluent)
☐ Direct CVS: min 10 mg direct villi
☐ Cultured CVS: 2 x T25 flasks (confluent)
☐ Tissue – Specify:
☐ Other – Specify:

Please check our website for test-specific requirements: muhc.ca/cmdl

CMDL - Laboratory use only:

Date – Time received:
/ /
h min

SAMPLE LABEL(S) HERE

Sample type and # of tubes:
Patient #:
Family #:

PATIENT STAMP OR LABEL HERE

Name (Last, First):*
Birth date (YYYY-MM-DD):* / /
Father's name:
Mother's name:
Medical Record # (MRN):*
RAMQ #:*
For babies, please provide mother's RAMQ #
Sex:* ☐ Male ☐ Female ☐ Unknown

Test Requested *(Write below OR check boxes on page 2)*:***

Reason for Testing:*

☐ Diagnostic testing (*affected case*)
☐ Carrier testing (*unaffected case – for recessive conditions*)
☐ Predictive testing (*unaffected case – for dominant conditions*)
☐ Prenatal testing (*maternal sample required*)
☐ Drug response (*pharmacogenetics*)
☐ Sample provided for trio/duo analysis
☐ Other – Specify:

Reason for expedited testing *(if applicable)*:

☐ Pregnancy (Gestational age: weeks on / /)
☐ Other – Specify:

Familial Variant Testing:

Please attach a copy of the proband's report. If the familial variant was not previously tested at the CMDL, please provide a sample from a family member known to be positive for this variant (i.e. a positive familial control).

Gene (HGNC symbol):
Variant(s) (HGVS format):
CMDL Family #:
Name of proband:
Relationship to proband:

Pedigree / Clinical Information:

Please draw or attach pedigree and provide relevant clinical information.

Ethnicity:*

Ordering Checklist:*

☐ Specimen tubes labelled with at least two identifiers*
☐ Completed test requisition (this form)*
☐ Completed test eligibility criteria form or information sheet (*if applicable*)
☐ Consent form

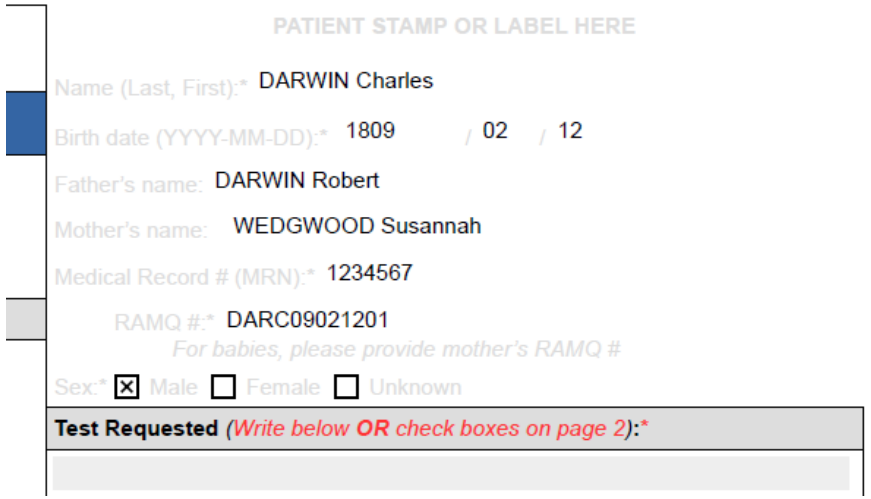
**Samples will not be processed if information is missing.*

DM-5891 (REV 2026-09-18) CUSM repro MUHC

Page 1/2

Molecular Genetics Requisition (continuation)

2. To start, fill the patient's information on the top right of the requisition.


PATIENT STAMP OR LABEL HERE

Name (Last, First):* DARWIN Charles

Birth date (YYYY-MM-DD):* 1809 / 02 / 12

Father's name: DARWIN Robert

Mother's name: WEDGWOOD Susannah

Medical Record # (MRN):* 1234567

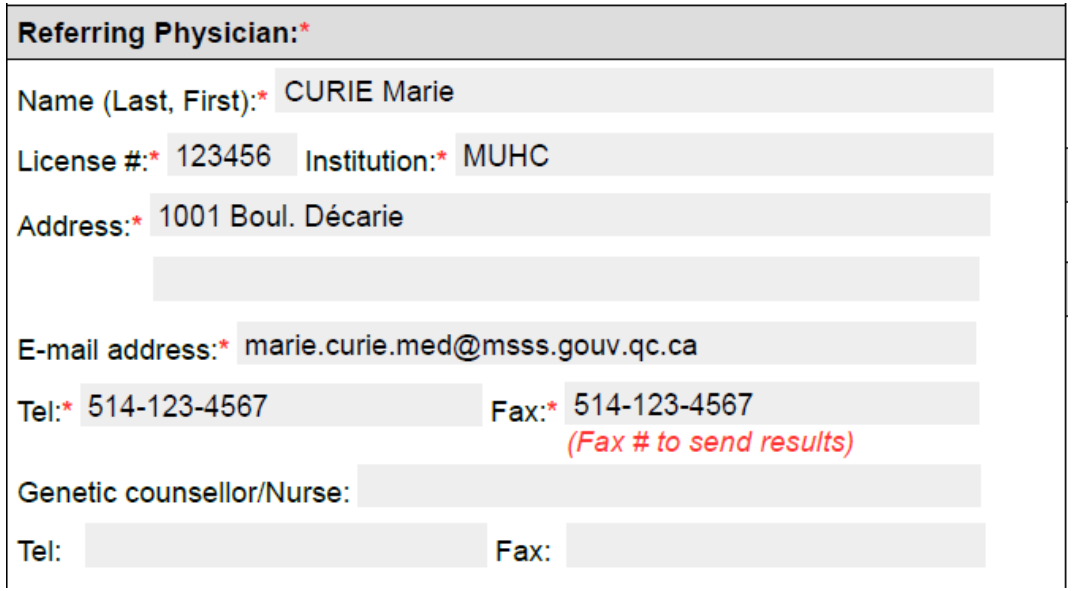
RAMQ #:* DARC09021201

For babies, please provide mother's RAMQ #

Sex:* ☒ Male ☐ Female ☐ Unknown

Test Requested *(Write below **OR** check boxes on page 2)*:*

3. Then add your information under « Referring Physician ». Please provide contact informations that will allow to quickly contact you if more details are required by the laboratory.


Referring Physician:*

Name (Last, First):* CURIE Marie

License #:* 123456 Institution:* MUHC

Address:* 1001 Boul. Décarie

E-mail address:* marie.curie.med@msss.gouv.qc.ca

Tel:* 514-123-4567 Fax:* 514-123-4567

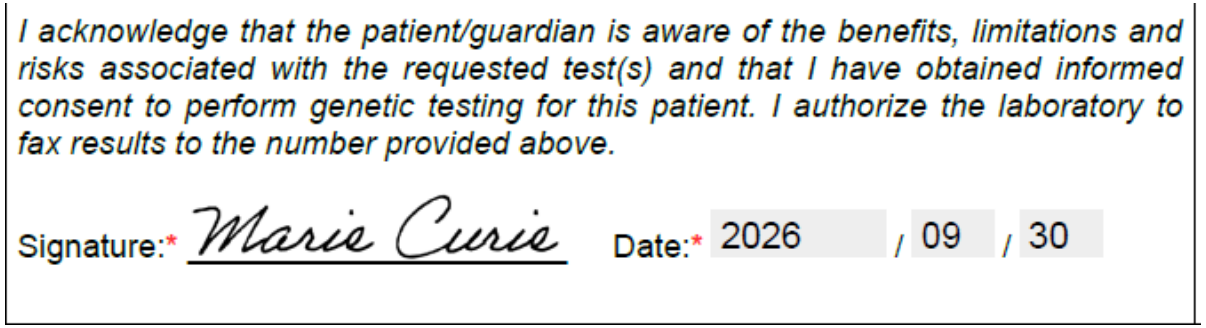
(Fax # to send results)

Genetic counsellor/Nurse:

Tel: Fax:

Molecular Genetics Requisition (continuation)

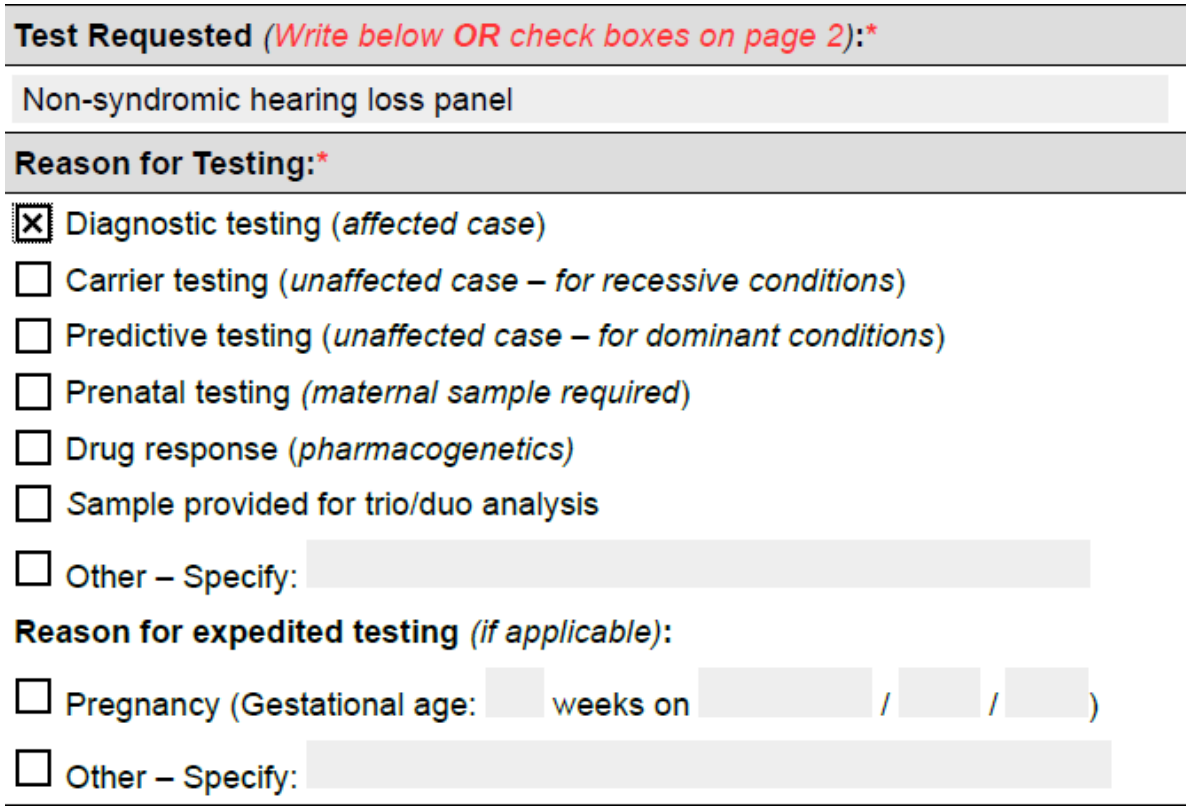
4. Take note of the consent statement just above the signature line. Once done, add your signature and the date.



I acknowledge that the patient/guardian is aware of the benefits, limitations and risks associated with the requested test(s) and that I have obtained informed consent to perform genetic testing for this patient. I authorize the laboratory to fax results to the number provided above.

Signature:* Marie Curie Date:* 2026 / 09 / 30

5. Under « Test Requested », write « Non-syndromic hearing loss panel » or « NSHL panel ». Then, under « Reason for Testing » check « Diagnostic testing (*affected case*) ».



Test Requested *(Write below **OR** check boxes on page 2)*:*

Non-syndromic hearing loss panel

Reason for Testing:*

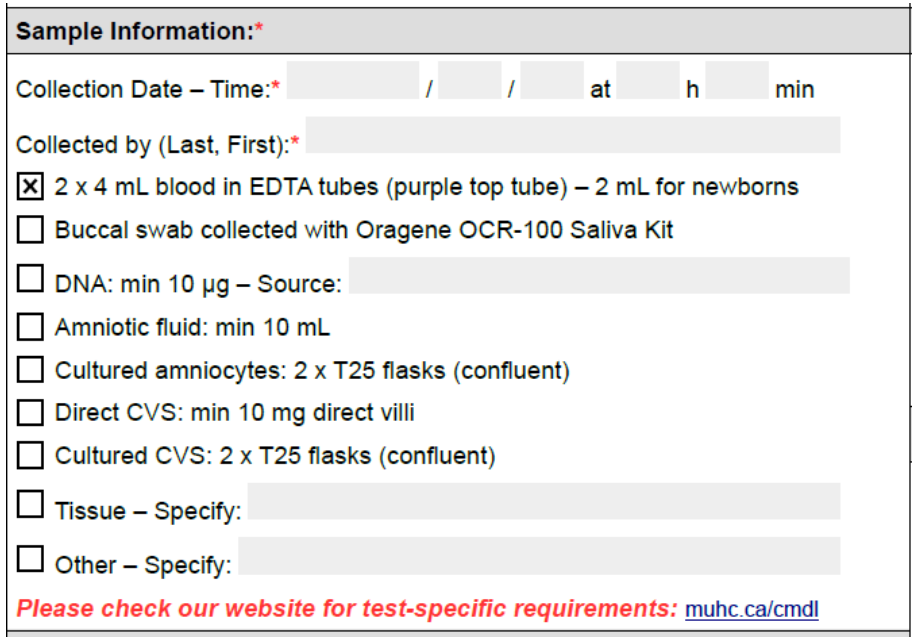
- [x] Diagnostic testing (*affected case*)
- [ ] Carrier testing (*unaffected case – for recessive conditions*)
- [ ] Predictive testing (*unaffected case – for dominant conditions*)
- [ ] Prenatal testing *(maternal sample required)*
- [ ] Drug response (*pharmacogenetics)*
- [ ] Sample provided for trio/duo analysis
- [ ] Other – Specify:

Reason for expedited testing *(if applicable)*:

- [ ] Pregnancy (Gestational age: weeks on / /)
- [ ] Other – Specify:

Molecular Genetics Requisition (continuation)

6. Under « Sample Information », check 2 x 4 ml in EDTA tubes to request a blood sampling for the patient.



Sample Information:*

Collection Date – Time:* / / at h min

Collected by (Last, First):*

☒ 2 x 4 mL blood in EDTA tubes (purple top tube) – 2 mL for newborns

☐ Buccal swab collected with Oragene OCR-100 Saliva Kit

☐ DNA: min 10 µg – Source:

☐ Amniotic fluid: min 10 mL

☐ Cultured amniocytes: 2 x T25 flasks (confluent)

☐ Direct CVS: min 10 mg direct villi

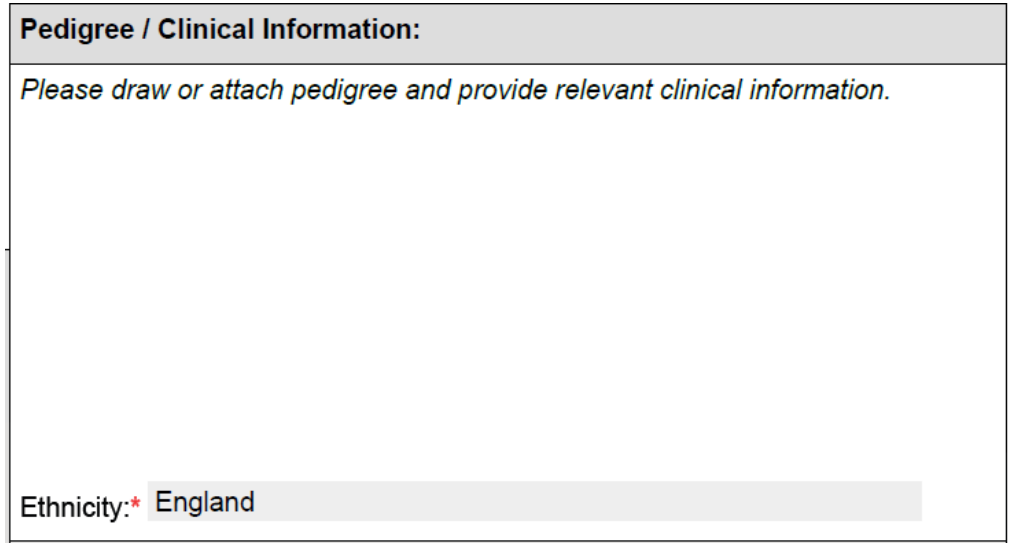
☐ Cultured CVS: 2 x T25 flasks (confluent)

☐ Tissue – Specify:

☐ Other – Specify:

Please check our website for test-specific requirements: muhc.ca/cmdl

7. Under « Pedigree/Clinical Information», draw a detailed pedigree if there are relevant relatives with hearing loss in the patient's family. Then, write the patient's ethnicity at the bottom.



Pedigree / Clinical Information:

Please draw or attach pedigree and provide relevant clinical information.

Ethnicity:* England

Molecular Genetics Requisition (continuation)

8. Under « Ordering Checklist », check the boxes « Completed testing requisition », « Completed test eligibility criteria form or information sheet » and « Consent form ».

9. You do not have to fill and print the second page of the requisition, unless you are ordering one or more test on top of the NSHL panel.

10. If you are ordering the test in Trio or Duo, you need to also fill a requisition for each parent. Fill the requisition in the exact same way as for the proband, but under « Reason for Testing » check « Sample provided for trio/duo analysis » instead.

Ordering Checklist:*

- ☐ Specimen tubes labelled with at least two identifiers*
- ☒ Completed test requisition (this form)*
- ☒ Completed test eligibility criteria form or information sheet (*if applicable*)
- ☒ Consent form

Samples will not be processed if information is missing.

Test Requested *(Write below **OR** check boxes on page 2)*:***

Non-syndromic hearing loss panel

Reason for Testing:*

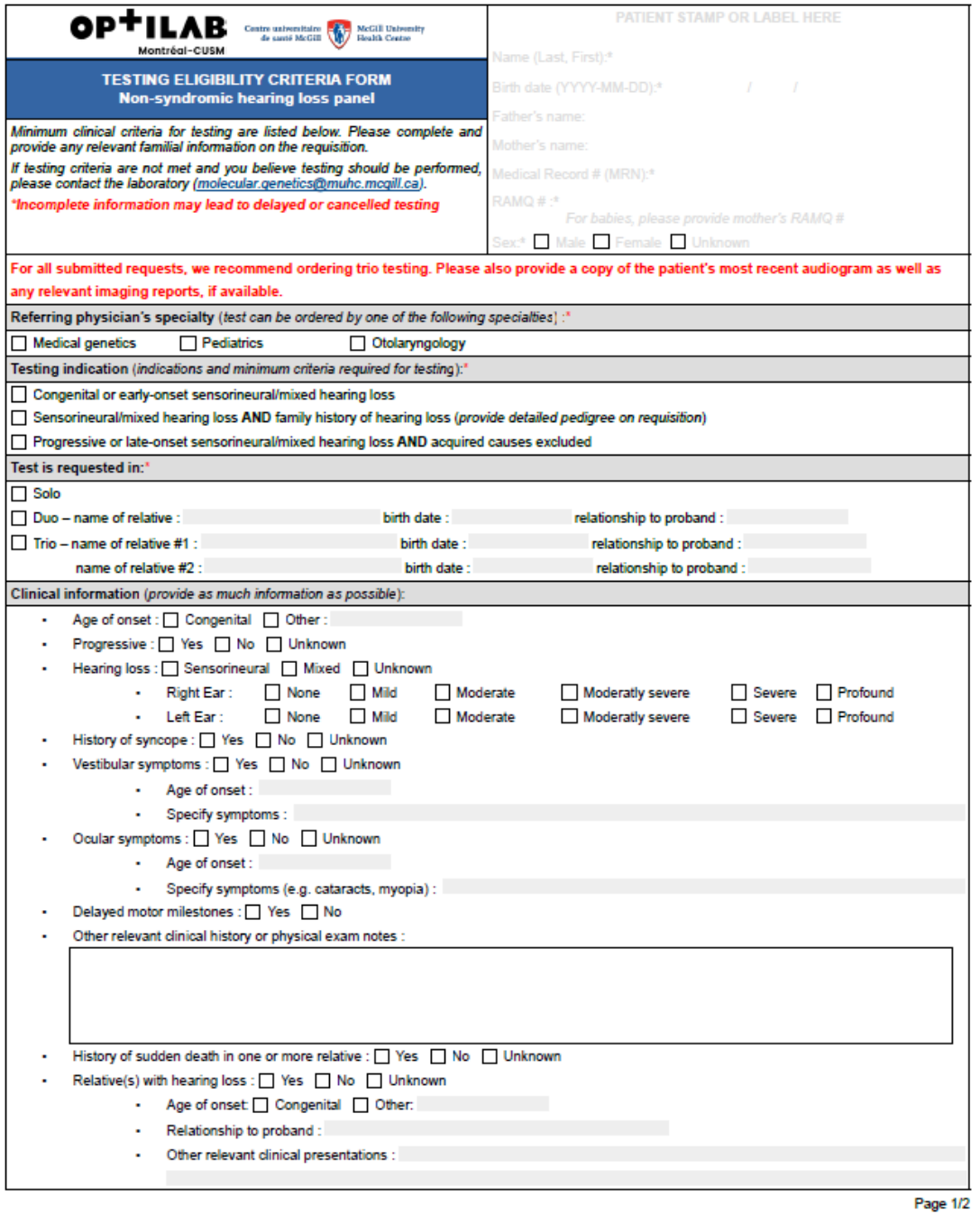
- ☐ Diagnostic testing (*affected case*)
- ☐ Carrier testing (*unaffected case – for recessive conditions*)
- ☐ Predictive testing (*unaffected case – for dominant conditions*)
- ☐ Prenatal testing *(maternal sample required)*
- ☐ Drug response (*pharmacogenetics)*
- ☒ Sample provided for trio/duo analysis
- ☐ Other – Specify:

Reason for expedited testing *(if applicable)*:

- ☐ Pregnancy (Gestational age: weeks on / /)
- ☐ Other – Specify:

Eligibility Criteria Form

1. See here the eligibility criteria form for the NSHL panel, which you can find at the following link (https://muhc.ca/sites/default/files/docs/m-Labs/Eligibility-criteria_Hearing-loss-clinome_v9_EN.pdf) You will need to fill this form.



OPTILAB Montréal-CUSM — Centre universitaire de santé McGill — McGill University Health Centre

TESTING ELIGIBILITY CRITERIA FORM
Non-syndromic hearing loss panel

Minimum clinical criteria for testing are listed below. Please complete and provide any relevant familial information on the requisition.

If testing criteria are not met and you believe testing should be performed, please contact the laboratory (molecular.genetics@muhc.mcgill.ca).

**Incomplete information may lead to delayed or cancelled testing*

PATIENT STAMP OR LABEL HERE

Name (Last, First):*
Birth date (YYYY-MM-DD):* / /
Father's name:
Mother's name:
Medical Record # (MRN):*
RAMQ # :*
For babies, please provide mother's RAMQ #
Sex:* ☐ Male ☐ Female ☐ Unknown

For all submitted requests, we recommend ordering trio testing. Please also provide a copy of the patient's most recent audiogram as well as any relevant imaging reports, if available.

Referring physician's specialty (*test can be ordered by one of the following specialties*) :*

☐ Medical genetics ☐ Pediatrics ☐ Otolaryngology

Testing indication (*indications and minimum criteria required for testing*):*

☐ Congenital or early-onset sensorineural/mixed hearing loss
☐ Sensorineural/mixed hearing loss **AND** family history of hearing loss (*provide detailed pedigree on requisition*)
☐ Progressive or late-onset sensorineural/mixed hearing loss **AND** acquired causes excluded

Test is requested in:*

☐ Solo
☐ Duo – name of relative : birth date : relationship to proband :
☐ Trio – name of relative #1 : birth date : relationship to proband :
name of relative #2 : birth date : relationship to proband :

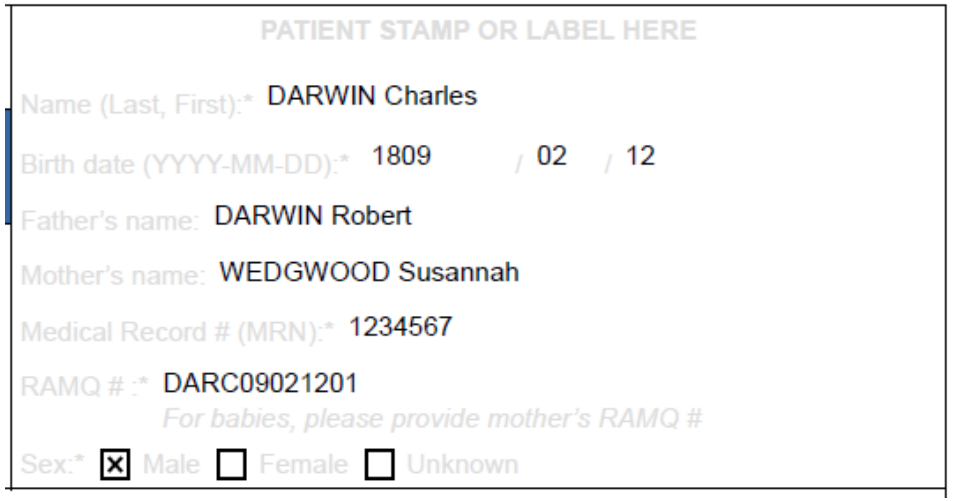
Clinical information (*provide as much information as possible*):

- Age of onset : ☐ Congenital ☐ Other :
- Progressive : ☐ Yes ☐ No ☐ Unknown
- Hearing loss : ☐ Sensorineural ☐ Mixed ☐ Unknown
  - Right Ear : ☐ None ☐ Mild ☐ Moderate ☐ Moderatly severe ☐ Severe ☐ Profound
  - Left Ear : ☐ None ☐ Mild ☐ Moderate ☐ Moderatly severe ☐ Severe ☐ Profound
- History of syncope : ☐ Yes ☐ No ☐ Unknown
- Vestibular symptoms : ☐ Yes ☐ No ☐ Unknown
  - Age of onset :
  - Specify symptoms :
- Ocular symptoms : ☐ Yes ☐ No ☐ Unknown
  - Age of onset :
  - Specify symptoms (e.g. cataracts, myopia) :
- Delayed motor milestones : ☐ Yes ☐ No
- Other relevant clinical history or physical exam notes :
- History of sudden death in one or more relative : ☐ Yes ☐ No ☐ Unknown
- Relative(s) with hearing loss : ☐ Yes ☐ No ☐ Unknown
  - Age of onset: ☐ Congenital ☐ Other:
  - Relationship to proband :
  - Other relevant clinical presentations :

Page 1/2

Eligibility Criteria Form (continuation)

2. First, fill the patient information the same way you did for the requisition.


PATIENT STAMP OR LABEL HERE

Name (Last, First):* DARWIN Charles

Birth date (YYYY-MM-DD):* 1809 / 02 / 12

Father's name: DARWIN Robert

Mother's name: WEDGWOOD Susannah

Medical Record # (MRN):* 1234567

RAMQ # :* DARC09021201

For babies, please provide mother's RAMQ #

Sex:* ☒ Male ☐ Female ☐ Unknown

3. Then, take note of the disclaimer at the top of the form.

For all submitted requests, we recommend ordering trio testing. Please also provide a copy of the patient's most recent audiogram as well as any relevant imaging reports, if available.

Eligibility Criteria Form (continuation)

4. Now indicate in which of the eligible specialty you practice under « Referring physician's specialty ». Only physicans belonging to one of those specialities are eligible to order this analysis.

Referring physician's specialty (*test can be ordered by one of the following specialties*) :*		
☒ Medical genetics	☐ Pediatrics	☐ Otolaryngology

5. Under « Testing indication », provide the primary reason for testing by checking the appropriate box. Note that your patient must fulfill one of these indications to be eligible for the analysis.

Testing indication (*indications and minimum criteria required for testing*):*
☒ Congenital or early-onset sensorineural/mixed hearing loss
☐ Sensorineural/mixed hearing loss **AND** family history of hearing loss (*provide detailed pedigree on requisition*)
☐ Progressive or late-onset sensorineural/mixed hearing loss **AND** acquired causes excluded

6. Under « Test is requested in » add the information that will allow the laboratory to connect your patient with their parents. First check in which state the test is requested (solo, duo or trio) and then add your patient's parent(s) name, birth date and relationship.

Test is requested in:*					
☐ Solo					
☐ Duo – name of relative :		birth date :		relationship to proband :	
☒ Trio – name of relative #1 :	DARWIN Robert	birth date :	1766-05-30	relationship to proband :	father
name of relative #2 :	WEDGWOOD Susannah	birth date :	1765-07-15	relationship to proband :	mother

Eligibility Criteria Form (continuation)

7. Finally, please add as much details as you can under « Clinical information ». This information will be used by the laboratory to correlate the genetic results with the patient's clinical presentations.

Clinical information (*provide as much information as possible*):

- Age of onset : ☒ Congenital ☐ Other :
- Progressive : ☐ Yes ☒ No ☐ Unknown
- Hearing loss : ☒ Sensorineural ☐ Mixed ☐ Unknown
  - Right Ear : ☐ None ☐ Mild ☒ Moderate ☐ Moderatly severe ☐ Severe ☐ Profound
  - Left Ear : ☐ None ☐ Mild ☐ Moderate ☐ Moderatly severe ☒ Severe ☐ Profound
- History of syncope : ☐ Yes ☐ No ☒ Unknown
- Vestibular symptoms : ☐ Yes ☒ No ☐ Unknown
  - Age of onset :
  - Specify symptoms :
- Ocular symptoms : ☒ Yes ☐ No ☐ Unknown
  - Age of onset : 5
  - Specify symptoms (e.g. cataracts, myopia) : High Myopia
- Delayed motor milestones : ☐ Yes ☒ No
- Other relevant clinical history or physical exam notes :
- History of sudden death in one or more relative : ☐ Yes ☐ No ☒ Unknown
- Relative(s) with hearing loss : ☒ Yes ☐ No ☐ Unknown
  - Age of onset: ☒ Congenital ☐ Other:
  - Relationship to proband : father
  - Other relevant clinical presentations :

Forwarding the Samples

1. Once you've filled and printed all the requisitions and the eligibility criteria form, have them forwarded with the samples and any other relevant documents to our laboratory at the address below.

Core Molecular Diagnostic Laboratory (CMDL)
1001 Decarie boul., E05.5051, Montreal, QC, H4A 3J1
Email: molecular.genetics@muhc.mcgill.ca
Tel: 514-934-1934 x23383 / x23298
Fax: 514-938-7405