

# Pathology Queensland Request Form

## Healthy Hearing Program

UR Number .....

Surname .....

Given Name ..... DOB ...../...../.....

Patient Address ..... Sex F M

P/code ..... Ph: .....

Tests Requested (State Specimen Type and Site)

**CMV PCR testing from  
Newborn Screening Card**

Note: no other tests  
can be ordered on this form

FIX LAB NO.  
HERE

LAB USE ONLY

**CMV PCR**

HCF	PP	From Ward	PP	Results to Ward/Clinic	PP
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Consultant: .....

Requesting Practitioner .....

Provider No .....

Signature .....

Date ...../...../.....

**Child diagnosed with permanent hearing loss**

Diagnostic Audiology Service: .....

Return Address of Requesting Practitioner: .....

Extra Copies To: Dr Address: .....	Extra Copies To: Dr Address: .....
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Note: Form will **not** be processed until this section is completed.

LABORATORY USE ONLY

Rec'd Time ..... Signed .....

**BILLING CATEGORY**

**HHP**

**Details of Child:** (if different from above)

Surname of Child .....

Given Name(s) of Child .....

Note: Please state the name of the child as registered by the hospital of birth

DOB of Child ...../...../..... Sex .....

Hospital of Birth .....

UR Number (if known) .....

**Details of Mother** (as registered by birth hospital):

Surname of Mother .....

Given Name(s) of Mother .....

Was the child transferred to another hospital prior to returning home?  
Yes/No

If Yes, which hospital .....

**Parental/Guardian Consent:**

I, \_\_\_\_\_ (mother/father/guardian) give permission for a blood spot from the Newborn Screening Card of the above mentioned child, which was collected on the birth of the abovementioned child and is currently held by the Newborn Screening Unit of Pathology Queensland, to be released to the Molecular Diagnostic Unit, Pathology Queensland and to be tested for Cytomegalovirus nucleic acid. I understand that the Healthy Hearing Program will be notified of the results and I may be contacted by staff associated with the Healthy Hearing Program. I also understand that de-identified data may be used for statistical reporting and research purposes. In signing this form, I confirm that I am the next of kin or the legal guardian of the child and the child has been diagnosed with a permanent hearing loss. I also acknowledge that the Molecular Diagnostic Unit will return the Newborn Screening Card and any unused specimens to the Newborn Screening Unit on completion of the test and that the specimen will not be used for any other testing without the written permission of the child's next of kin or legal guardian. I understand that although the identification of Cytomegalovirus nucleic acid on this test may indicate a possible cause of the child's permanent hearing loss it does not exclude other possible causes of the permanent hearing loss and that other testing may also be recommended for the child.

Signature (mother/father/guardian) ..... Date ...../...../..... Contact Number .....

Note: You will not be charged for this service

Note: If a Newborn Screening Card matching the information above is not found you will be contacted for further information to help identify the child's Newborn Screening Card.

**Requesting Practitioner's Statement:**

- I have explained to the mother/father/guardian the testing procedure, its purpose and its limitations
- I have given the mother/father/guardian an opportunity to ask questions about any of the above matters and raise any other concerns which I have answered as fully as possible. I am of the opinion that the mother/father/guardian understood the information provided.

Signature (Requesting Practitioner) ..... Date ...../...../..... Contact Number .....

Was an interpreter required? Yes/No

If yes, was an interpreter present? Yes/No

Please complete and return via post to: Reply Paid 65961  
Newborn Screening Unit  
Pathology Queensland  
Level 3, Block 7  
RBWH  
QLD 4029

Or alternatively scan and email to:  
neonatal\_screening@health.qld.gov.au