



**Instructions:** This form is intended to be completed by the ordering healthcare professional. Accurate interpretation and reporting of genetic results is contingent upon the reason for testing, clinical information, family history and ancestry. To help provide the best possible service, supply the information requested below and **send paperwork with the specimen, or return by fax to Mayo Clinic Laboratories, Attn: Molecular Technologies Laboratory Genetic Counselors at 507-284-1759. Phone: 800-533-1710 / International clients: 855-379-3115 or +1-507-284-9273, or email [mliintl@mayo.edu](mailto:mliintl@mayo.edu).**

### Patient Information

Patient Name (Last, First Middle)		Birth Date (mm-dd-yyyy)
Preferred Name		Medical Record Number (if Birth Date is not available)
Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other, specify: _____	Legal/Administrative Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other, specify: _____	
Gender Identity (optional)	Pronouns (optional)	

### Referring Healthcare Professional Information

Referring Healthcare Professional Name (Last, First)	Phone	Fax*
Genetic Counselor/Other Healthcare Professional Name (Last, First)	Phone	Fax*

\*Fax number given must be from a fax machine that complies with applicable HIPAA regulations.

### Reason for Testing

Diagnosis  Prenatal  Biological Family History\*\*  Other, specify: \_\_\_\_\_

\*\*Genetic testing should be performed on an affected biological family member first, when possible. FMTT / Familial Variant, Targeted Testing should be ordered when there is a previous positive genetic test result in the family.

### Clinical History

Indicate whether the following are present. Check all that apply.

Has the patient had a microarray?  Yes  No  
If "Yes," attach results.

Anomalous pulmonary venous return (APVR)  
 Total anomalous pulmonary return (APVR)  
 Partial anomalous pulmonary return (TAPVR)

Atrioventricular Septal Defect (AVSD)  
 Primum atrial septal defect (ASD)  
 Inlet ventricular septal defect (VSD)  
 Complete AVSD/complete atrioventricular (AV) canal defect  
 AVSD + outflow tract obstruction

Complex  
 Multiple complex heart anomalies  
 Complex single ventricle defects  
 Levo-transposition of the great arteries (L-TGA)

Conotruncal  
 Double outlet right ventricle (DORV)  
 Truncus arteriosus (TA)  
 Interrupted aortic arch (IAA)  
 Interrupted aortic arch type B (IAA-B)  
 Dextro-transposition of the great arteries (D-TGA)  
 Tetralogy of Fallot (TOF)  
 Mitral valve atresia (MA)  
 Shone's complex

Left ventricular outflow tract obstruction (LVOTO)  
 Bicuspid aortic valve (BAV)  
 Hypoplastic left heart syndrome (HLHS)  
 Aortic stenosis (AS (+/- CoA))  
 Coarctation of the aorta (CoA) (+/- ventricular septal defect (VSD))

Right ventricular outflow tract obstruction (RVOTO)  
 Pulmonary atresia (PA) (+/- VSD)  
 Pulmonary valve stenosis (PVS) (+/- ASD or any noninlet VSD)  
 Ebstein anomaly  
 Tricuspid atresia

Septal  
 Ventricular septal defect (VSD) (nonspecific)  
 VSD (perimembranous, muscular, or noninlet)  
 Secundum atrial septal defect (ASD)  
 Multiple co-occurring ASD or VSD  
 Other, indicate: \_\_\_\_\_

# Congenital Heart Disease Genetic Testing

## Patient Information (continued)

Patient Name <small>(Last, First Middle)</small>	Birth Date <small>(mm-dd-yyyy)</small>
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### Biological Family History

Are there similarly affected biological relatives? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," indicate relationship and symptoms: _____
Have any biological family members had genetic testing? <input type="checkbox"/> Yes*** <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>***FMTT / Familial Variant, Targeted Testing should be ordered when there is a previous positive genetic test result in the family. Contact the lab for ordering assistance.</b>
History of consanguinity <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Yes; biological relationship details: _____

### Patient Ancestry

Ancestry: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Choose not to disclose
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**New York State Patients: Informed Consent for Genetic Testing is required.** See Informed Consent for Genetic Testing (T576) or Informed Consent for Genetic Testing – Spanish (T826).