



Combined Immunodeficiency, Severe Combined Immunodeficiency, and B-Cell/Antibody Deficiency Patient Information

Instructions: 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 800-533-1710. Phone: 507-266-5700 / International clients: +1-507-266-5700 or email MLIINT@mayo.edu

Patient Information

Form with fields for Patient Name (Last, First, Middle), Birth Date (mm-dd-yyyy), Sex Assigned at Birth (Male, Female, Unknown, Choose not to disclose), and Legal/Administrative Sex (Male, Female, Nonbinary).

Referring Provider Information

Form with fields for Referring Provider Name (Last, First), Phone, Fax*, Genetic Counselor Name (Last, First), Phone, and Fax*.

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

Reason for Testing Specify below or attach relevant clinic note.

Form with checkboxes for Confirm clinical diagnosis, Newborn screening follow-up, Family history, and Other, specify. Includes a note about genetic testing on affected family members.

Infectious Disease History

Form with checkboxes for Recurrent or difficult to treat infections (Viral, Bacterial, Fungal), Recurrent pneumonia, Recurrent deep abscesses, Gastrointestinal infections, Skin infections, Conjunctivitis, Meningitis, Sepsis, Other infection, Multiple courses of antibiotics, and On immunoglobulin replacement.

**Combined Immunodeficiency,
Severe Combined Immunodeficiency,
and B-Cell/Antibody Deficiency
Patient Information** (continued)

Patient Name (Last, First, Middle)	Birth Date (mm-dd-yyyy)
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General History

<input type="checkbox"/> Alopecia	<input type="checkbox"/> Failure to thrive
<input type="checkbox"/> Ataxia	<input type="checkbox"/> Graft vs host disease
<input type="checkbox"/> Bone abnormalities, describe: _____	<input type="checkbox"/> Granulomas
<input type="checkbox"/> Bronchiectasis	<input type="checkbox"/> Hepatosplenomegaly
<input type="checkbox"/> Celiac disease	<input type="checkbox"/> Lymphadenopathy
<input type="checkbox"/> Decreased lymphoid tissue (small adenoids, tonsils, lymph nodes)	<input type="checkbox"/> Oral candidiasis
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Osteopenia
<input type="checkbox"/> Eczema	<input type="checkbox"/> Pruritic dermatitis
<input type="checkbox"/> Endocrine abnormalities, describe: _____	<input type="checkbox"/> Telangiectasia
<input type="checkbox"/> Enteropathy, describe: _____	<input type="checkbox"/> Thymic defect, describe: _____
<input type="checkbox"/> Erythroderma	

Patient Treatment History

Has the patient received an allogenic stem cell transplant***? <input type="checkbox"/> No <input type="checkbox"/> Yes; transplant date (mm-dd-yyyy): _____
Is the patient transfusion-dependent***? <input type="checkbox"/> No <input type="checkbox"/> Yes; last transfusion date (mm-dd-yyyy): _____ Was this transfusion leukoreduced***? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Chemotherapy: <input type="checkbox"/> No <input type="checkbox"/> Yes; date (mm-dd-yyyy): _____
***Results may be inaccurate due to the presence of donor DNA if the patient has received an allogeneic hematopoietic stem cell transplant or non-leukocyte reduced blood products. Call Mayo Clinic Laboratories for instructions for testing patients who have received a bone marrow transplant.

Family History

Are there similarly affected relatives? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," indicate relationship, and diagnosis or symptoms: _____
Have any family member had genetic testing? <input type="checkbox"/> Yes**** <input type="checkbox"/> No <input type="checkbox"/> Unknown ****FMTT / Familial Mutation Targeted Testing should be ordered when there is a previous positive genetic test result in the family. Contact the lab for ordering assistance.
History of consanguinity: <input type="checkbox"/> No <input type="checkbox"/> Yes; relationship details: _____

Ancestry

<input type="checkbox"/> African/African American	<input type="checkbox"/> East Asian	<input type="checkbox"/> Latinx/Latine	<input type="checkbox"/> South Asian	<input type="checkbox"/> Unknown
<input type="checkbox"/> Ashkenazi Jewish	<input type="checkbox"/> European	<input type="checkbox"/> Middle Eastern	<input type="checkbox"/> None of the above	<input type="checkbox"/> Choose not to disclose

New York State Patients: Informed Consent for Genetic Testing is required. See Informed Consent for Genetic Testing (T576), Informed Consent for Genetic Testing – Spanish (T826), or Informed Consent for Genetic Testing for Deceased Individuals (T782).