Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Primary Ciliary Dyskinesia Genetic Testing Patient Information

Instructions: This form is intended to be completed by the ordering healthcare professional. Accurate interpretation and reporting of genetic results is contingent upon ancestry, reason for testing, clinical information, and family history. 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.**

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 ☐ Male ☐ Female ☐ Choose not to disclose ☐ Other, specify:	Legal/Administrative Sex ☐ Male ☐ Female ☐ Nonbinary ☐ Choose not to disclose ☐ Other, specify:	
Gender Identity (optional)	Pronouns (optional)	

Referring Healthcare Professional Information

Requesting 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 ☐ 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

Clinical Findings

☐ Situs abnormality
- ☐ Situs inversus totality
- ☐ Heterotaxy
- ☐ Dextrocardia/Congenital heart defect
- ☐ Asplenia/Polysplenia
- ☐ Pulmonary isomerism
- ☐ **Other, specify:**

☐ Chronic nasal congestion

☐ Chronic sinusitis

☐ Pulmonary disease
- ☐ Neonatal respiratory distress
- ☐ Chronic airway infections
- ☐ Bronchiectasis
- ☐ Pulmonary calcium deposits

☐ Chronic or recurrent ear infections

☐ Infertility

Laboratory Findings

☐ Abnormal ciliary ultrastructure
- ☐ Shortening/Absence of outer dynein arms
- ☐ Shortening/Absence of both outer and inner dynein arms
- ☐ Microtubular disorganization
- ☐ Absence/Disruption of the central apparatus
- ☐ Other, specify:

☐ Abnormal ciliary motility

☐ Low nasal nitric oxide: nl/min

Other Relevant Clinical History

Primary Ciliary Dyskinesia Genetic Testing
Patient Information (continued)

Biological Family History

Are there similarly affected biological relatives? ☐ Yes ☐ No

If "Yes," indicate relationship and symptoms:

Have any biological family members had genetic testing? ☐ Yes*** ☐ No ☐ Unknown

*****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.**

History of consanguinity: ☐ No ☐ Unknown ☐ Choose not to disclose

☐ Yes; relationship details:

Patient Ancestry

Ancestry: ☐ Unknown ☐ Choose not to disclose

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).

Print