Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

PRKAR1A-Related Conditions Patient Information

Instructions: Accurate interpretation and reporting of genetic results is contingent upon the reason for testing, clinical information, ancestry, 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: +1-507-266-5700 or email MLIINT@mayo.edu**

Patient Information

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

Sex Assigned at Birth	Legal/Administrative Sex
☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose	☐ Male ☐ Female ☐ Nonbinary

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/Suspected Diagnosis

☐ Carney complex (CNC) ☐ Acrodysostosis-1 with hormone resistance ☐ Other; specify:

Clinical Information

Indicate if the following are present:

Tumors

☐ Myxoma; if present, indicate locations: ☐ Cardiac ☐ Skin ☐ Breast ☐ Oropharynx ☐ Genital tract
☐ Primary pigmented nodular adrenocortical disease (PPNAD)
☐ Large-cell calcifying Sertoli cell tumor (LCCSCT)
☐ Thyroid nodules/Thyroid adenoma/Thyroid carcinoma
☐ Growth hormone-producing adenoma
☐ Psammomatous melanotic schwannoma (PMS)
☐ Breast ductal adenoma
☐ Other; specify:

Skeletal

☐ Short stature ☐ Brachycephaly ☐ Short, broad hands ☐ Advanced bone age ☐ Acromegaly
☐ Other; specify:

Developmental

☐ Developmental delay ☐ Other; specify:

Cutaneous

☐ Lentigines ☐ Pigmented nevi ☐ Blue nevi ☐ Other; specify:

Endocrine

☐ Hormone resistance ☐ Irregular menses ☐ Hypogonadism ☐ Other; specify:

Indicate any additional features present:

Ancestry

☐ African/African American	☐ East Asian	☐ Latinx/Latine	☐ South Asian	☐ Unknown
☐ Ashkenazi Jewish	☐ European	☐ Middle Eastern	☐ None of the above	☐ Choose not to disclose

Family History

Are other relatives known to be affected? ☐ Yes** ☐ No

If "Yes," indicate their diagnosis and relationship to the patient:

Have other relatives had molecular genetic testing? ☐ Yes ☐ No

****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.**

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