



Bruton Tyrosine Kinase (BTK) Gene Sequencing 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 the reason for testing, clinical information, family history, and ancestry. To help provide the best possible service, supply the information requested below and **send this 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 (required)

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 (required)

Requesting Healthcare Professional Name (Last, First)	Phone	Fax*
Genetic Counselor Name (Last, First)	Phone	Fax*

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

Reason for Testing Check all that apply.

Diagnosis Biological Family History** Carrier Screening** Other, specify: _____

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

Clinical History

Patient's clinical status: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic <input type="checkbox"/> Other: _____		
Has the patient received immunoglobulin treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Hypogammaglobulinemia (low IgG, IgM, IgA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinusitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Common Variable Immunodeficiency (CVID)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsils present <input type="checkbox"/> Yes <input type="checkbox"/> No
Recurrent infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lymph nodes present <input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Splenomegaly <input type="checkbox"/> Yes <input type="checkbox"/> No
CD19+ B-cells present in blood (>1%)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Btk protein by flow cytometry	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Equivocal <input type="checkbox"/> Carrier <input type="checkbox"/> Unknown	
Other Diagnosis		
Other Information (such as allogeneic stem cell transplant; indicate type [myeloablative vs. non-myeloablative] and date)		

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Biological Family History

Normal	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Siblings
Hypogammaglobulinemia (low IgG and/or IgM, IgA)	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Siblings
CVID	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Siblings
Recurrent infections	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Siblings
Are other male biological relatives known to be affected?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes," indicate their biological relationship to the patient: _____			
Are other female biological relatives known to be a carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes," indicate their biological relationship to the patient: _____			
Have other biological relatives had molecular genetics testing?***	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes," indicate their biological relationship to the patient: _____			
If the relative was tested at Mayo Clinic, include the name of the biological family member: _____			
***FMTT / Familial Variant, Targeted Testing should be used when there is a previous positive genetic test result in the biological family. Contact the lab for ordering assistance.			

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).