



Instructions: The accurate interpretation and reporting of the genetic results is contingent upon the reason for referral, 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: Personalized Genomics Laboratory Genetic Counselors at 507-284-1759. Phone: 507-266-5700 / International clients: +1-507-266-5700 or email MLIINT@mayo.edu

Patient Information

Form with fields for Patient Name, Birth Date, Sex, Referring Provider Name, Phone, Fax, and Other Contact Name.

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

Reason for Testing Check all that apply.

Form with checkboxes for Diagnosis, Presymptomatic diagnosis, Prenatal, Family History, Transplant Evaluation, and Other; specify.

Indications Check all that apply.

Large form with multiple columns of checkboxes for various kidney conditions such as Alagille syndrome, Alport syndrome, Complement defects, Congenital anomalies of the kidney and urinary tract (CAKUT), Cystic kidney disease, FSGS/SRNS, Nephrolithiasis/Nephrocalcinosis, Bartter syndrome, Renal electrolyte abnormalities and related disorders, and Prenatal abnormalities.

Hereditary Renal Genetic Testing Patient Information (continued)

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

<p>General Renal History</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hematuria <input type="checkbox"/> Proteinuria <input type="checkbox"/> Aminoaciduria <input type="checkbox"/> Glucosuria <input type="checkbox"/> Polyuria <input type="checkbox"/> Oliguria <input type="checkbox"/> Renal salt wasting <input type="checkbox"/> Systemic lupus <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Acute kidney failure/injury <input type="checkbox"/> Exposure to nephrotoxic medications <input type="checkbox"/> Infectious disease; specify: _____ <p>Extra-Renal Findings</p> <ul style="list-style-type: none"> <input type="checkbox"/> Intracranial aneurysm <input type="checkbox"/> Retinitis pigmentosa or vision loss <input type="checkbox"/> Heterotaxy <input type="checkbox"/> Abnormal brain MRI; specify: _____ <input type="checkbox"/> Dysmorphic facial features; specify: _____ <input type="checkbox"/> Ear abnormalities; specify: _____ <input type="checkbox"/> Other; specify: _____ <p>Other Clinical History</p> <ul style="list-style-type: none"> <input type="checkbox"/> History of kidney transplant <input type="checkbox"/> History of immunosuppressive therapy <input type="checkbox"/> History of allogeneic hematopoietic stem cell transplantation*** <input type="checkbox"/> Other; describe: _____ <p>Current Medications:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Laboratory Findings</p> <p>Kidney Biomarkers</p> <ul style="list-style-type: none"> <input type="checkbox"/> eGFR/GFR: _____ <input type="checkbox"/> Creatinine clearance: _____ <input type="checkbox"/> TmP/GFR: _____ <input type="checkbox"/> Other; specify: _____ <p>Urine; describe or attach results from any abnormal urine labs:</p> <p>_____</p> <p>_____</p> <p>Pathology</p> <ul style="list-style-type: none"> <input type="checkbox"/> Kidney biopsy; describe or attach pathology results: _____ <p>Complement Serology</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> AH50:</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> C3:</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> C4:</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> C5:</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> CH50:</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> Factor B:</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> Factor D:</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> Factor H:</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> Factor I:</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> FH antibodies:</td> <td><input type="checkbox"/> Absent</td> <td><input type="checkbox"/> Present</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other; specify: _____</td> </tr> </table> <p>Soluble Biomarkers</p> <ul style="list-style-type: none"> <input type="checkbox"/> Shiga toxin: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> ADAMTS13: Activity _____%, Level _____ <p>Blood; describe or attach results from any abnormal blood labs:</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/> AH50:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> C3:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> C4:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> C5:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> CH50:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Factor B:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Factor D:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Factor H:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Factor I:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> FH antibodies:	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Other; specify: _____		
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***Note: A previous bone marrow transplant from an allogeneic donor will interfere with testing. Call 800-533-1710 for instructions for testing patients who have received a bone marrow transplant.

Family History

Are there similarly affected relatives? Yes No If Yes, indicate relationship and symptoms:

Have any family members had genetic testing? Yes**** No 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: Yes No If Yes, relationship details: _____

Ancestry

<input type="checkbox"/> African/African American	<input type="checkbox"/> East Asian	<input type="checkbox"/> Latino/Latina	<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).