Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

GATA2 Gene Sequencing Patient Information

Instructions: The accurate interpretation and reporting of genetic results is contingent upon the reason for testing, clinical history, 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 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 Provider Information

Referring Provider Name (Last, First)	Phone	Fax*
Other Contact/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

☐ Diagnosis ☐ Family history** ☐ Other; specify:

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

Clinical History Check all that apply.

Patient's clinical status: ☐ Asymptomatic ☐ Symptomatic ☐ Other:

Indicate whether the following are present:

☐ Warts
☐ Cytopenias (neutropenia, monocytopenia, B cell/NK cell/CD4+ T cell lymphopenia)
☐ Other malignancies; specify:
☐ Lymphedema (eg, legs, genitals); specify:
☐ Myelodysplastic syndrome (MDS)
☐ Mycobacterial disease
☐ Acute myeloid leukemia (AML)
☐ Viral infections
☐ Pulmonary alveolar proteinosis (PAP)
☐ Emberger syndrome

Preliminary screening results:

☐ WBC: ; Absolute Neutrophil count: ; Monocyte count: ; Absolute Lymphocyte count:
☐ B cell count: ; CD4 T cell count: ; CD8 T cell count: ; NK cell count:
☐ Dendritic cell count: ; Dendritic cell phenotyping:

Patient treatment history:

☐ No treatment ☐ Chemotherapy ☐ Allogeneic Hematopoietic cell transplant (blood, BM, cord); transplant date (mm-dd-yyyy):
☐ Treatment for infections; specify:

Other relevant clinical history:

Diagnosis date, if applicable (mm-dd-yyyy):

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 Variant, Targeted Testing should be ordered when there is a previous positive genetic test result in the family. Contact the lab for ordering assistance.**

Ancestry

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

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