Complete and print.

MAYO CLINIC LABORATORIES

# Chromosomal Microarray Prenatal and Products of Conception Information

Reset Form

**Instructions:** The accurate interpretation and reporting of genetic results is contingent upon the reason for referral, clinical information provided, and family history. Supply the information requested below and **send paperwork with the specimen or return by fax to Mayo Clinic Laboratories, Attn: Cytogenetics Lab 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) |
|---|---|
| Sex Assigned at Birth ☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose | Legal/Administrative Sex ☐ Male ☐ Female ☐ Nonbinary |

## Referring Healthcare Professional Information (required)

| Referring Healthcare Professional Name (Last, First) | Phone | Email* | *Any communication sent via email will comply with applicable HIPAA regulations.* |
|---|---|---|---|
| Genetic Counselor Name (Last, First) | Phone | Email* | |

## Reason for Testing

Is donor egg or gestational carrier involved in this pregnancy? ☐ Yes ☐ No

## Clinical Information Check all that apply.

**Primary Indication for Testing**
- ☐ Advanced maternal age
- ☐ Fetal abnormality
- ☐ Abnormal maternal serum screening
- ☐ Abnormal cell-free DNA screening (NIPT, NIPS, cfDNA); increased risk for: _____

**Perinatal History**
- ☐ 2 vessel cord
- ☐ Hydrops
- ☐ Increased nuchal translucency (includes cystic hygroma)
- ☐ Intrauterine growth restriction (IUGR)
- ☐ Oligohydramnios
- ☐ Polyhydramnios
- ☐ Other: _____

**Neurological**
- ☐ Abnormal gyri (lissencephaly)
- ☐ Agenesis of the corpus callosum
- ☐ Cerebellar hypoplasia
- ☐ Dandy Walker
- ☐ Decreased fetal movement
- ☐ Holoprosencephaly
- ☐ Neural tube defect
- ☐ Structural brain anomaly
- ☐ Ventriculomegaly/hydrocephaly
- ☐ Other: _____

**Craniofacial**
- ☐ Cleft lip +/- palate
- ☐ Macrocephaly
- ☐ Microcephaly
- ☐ Other: _____

**Cardiac**
- ☐ Aortic atresia
- ☐ Atrial septal defect
- ☐ Atrioventricular (AV) canal defect
- ☐ Coarctation of the aorta
- ☐ Dextrocardia/situs inversus
- ☐ Double outlet right ventricle
- ☐ Ebstein anomaly
- ☐ Echogenic intracardiac focus
- ☐ Hypoplastic left heart
- ☐ Hypoplastic right heart
- ☐ Tetralogy of Fallot
- ☐ Transposition of the great vessels
- ☐ Truncus arteriosus
- ☐ Ventricular septal defect
- ☐ Other: _____

**Pulmonary**
- ☐ Congenital cystic adenomatoid malformation (CCAM)/small thoracic cavity
- ☐ Diaphragmatic hernia
- ☐ Pleural effusion
- ☐ Pulmonary sequestration
- ☐ Other: _____

**Gastrointestinal**
- ☐ Absent stomach
- ☐ Echogenic focus
- ☐ Gastroschisis
- ☐ Meconium ileus/anal atresia
- ☐ Omphalocele
- ☐ Tracheoesophageal fistula
- ☐ Other: _____

**Musculoskeletal**
- ☐ Acromelia
- ☐ Clenched hands
- ☐ Club foot
- ☐ Contractures (arthrogryposis)
- ☐ Limb anomaly
- ☐ Mesomelia/micromelia
- ☐ Polydactyly
- ☐ Skeletal dysplasia
- ☐ Syndactyly
- ☐ Vertebral anomaly
- ☐ Other: _____

**Genitourinary**
- ☐ Ambiguous genitalia
- ☐ Hydronephrosis kidney malformation
- ☐ Megacystis (including posterior valves)
- ☐ Polycystic kidneys
- ☐ Renal agenesis
- ☐ Urethra/ureter obstruction
- ☐ Other: _____

**Family History**
- ☐ Parents with 2 or more miscarriages
- ☐ Other relatives with previous pregnancies with similar clinical history (explain below):

- ☐ Other: _____

## Clinical Descriptions Include any additional relevant clinical information. List all previous genetic testing and provide a report.



Print