Complete and print.

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MAYO CLINIC LABORATORIES

# Molecular Genetics: Prenatal Patient Information

**Instructions:** The accurate interpretation and reporting of genetic results is contingent upon the reason for testing and clinical information. 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: 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) |
|---|---|---|
| Sex Assigned at Birth<br>☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose | Legal/Administrative Sex<br>☐ Male ☐ Female ☐ Nonbinary | |

## Referring Healthcare Professional Information

| 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

☐ Abnormal ultrasound, details:
☐ Abnormal testing, (complete Previous Testing section below):
☐ Family history, details:
☐ Other, details:

## Clinical Information

**Donor Egg**
☐ Yes ☐ No ☐ Unknown

Gestational Age at Collection of Fetal Sample: weeks days

**Fetal Specimen Source**
☐ Direct Chorionic Villi
☐ Direct Amniotic Fluid
☐ Fetal Blood (PUBS)
☐ Cultured Chorionic Villi
☐ Cultured Amniotic Fluid
☐ Other, source:

**Fetal Sex**
☐ Male ☐ Female ☐ Unknown

**Multiple Gestation Pregnancy**
☐ Twins ☐ Triplets ☐ Other:

**Fetal Sample Collection Date** (mm-dd-yyyy):

**Maternal Blood Collection Date** (mm-dd-yyyy):
☐ Maternal sample not available

**Previous Testing** (include a copy of any previous test results)
☐ Karyotype/Microarray, list result(s):

☐ Other, list result(s):
☐ Parent(s) known to be carrier (indicate condition and include a copy of their carrier report[s]):
☐ Cytogenetic testing to be performed at Mayo Clinic, indicate desired test codes**:
☐ Cytogenetic testing not needed at Mayo Clinic

** See Lab Test Catalog for available cytogenetic tests and ordering guidance.

# Molecular Genetics: Prenatal
# Patient Information (continued)

## Test Selection

**Maternal Sample**

- ☐ CYPZ / 21-Hydroxylase Gene, CYP21A2, Full Gene Analysis, Varies (sent as positive control)
- ☐ FMTT / Familial Variant, Targeted Testing, Varies (sent as positive control)
- ☐ MATCC / Maternal Cell Contamination, Molecular Analysis, Varies§
- ☐ UNIPD / Uniparental Disomy, Varies§
- ☐ Other:

**Fetal Sample**

- ☐ MATCC / Maternal Cell Contamination, Molecular Analysis, Varies§
- ☐ BWRS / Beckwith-Wiedemann Syndrome/Russell-Silver Syndrome, Molecular Analysis, Varies
- ☐ CHDGG / Congenital Heart Disease Gene Panel, Varies†
- ☐ CKDGP / Cystic Kidney Disease Gene Panel, Varies†
- ☐ CYPZ / 21-Hydroxylase Gene, CYP21A2, Full Gene Analysis, Varies¶
- ☐ DBMD / Duchenne/Becker Muscular Dystrophy, DMD Gene, Large Deletion/Duplication Analysis, Varies
- ☐ F81P / Hemophilia A F8 Gene, Intron 1 Inversion Known Mutation Analysis, Prenatal†
- ☐ F822P / Hemophilia A F8 Gene, Intron 22 Inversion Mutation Analysis, Prenatal†
- ☐ FMTT / Familial Variant, Targeted Testing, Varies§§
- ☐ FXS / Fragile X Syndrome, Molecular Analysis, Varies
- ☐ NSRGG / Noonan Syndrome and Related Conditions Gene Panel, Varies†
- ☐ OIBFG / Osteogenesis Imperfecta and Bone Fragility Gene Panel, Varies†
- ☐ PWAS / Prader-Willi/Angelman Syndrome, Molecular Analysis, Varies
- ☐ SMNDX / Spinal Muscular Atrophy Diagnostic Assay, Deletion/Duplication Analysis, Varies
- ☐ UNIPD / Uniparental Disomy, Varies§ (chromosome[s] to be tested: )
- ☐ Other:

**Paternal Sample** (if applicable)

- ☐ Paternal sample unavailable for testing
- ☐ CYPZ / 21-Hydroxylase Gene, CYP21A2, Full Gene Analysis, Varies (sent as positive control)
- ☐ FMTT / Familial Variant, Targeted Testing, Varies (sent as positive control)
- ☐ UNIPD / Uniparental Disomy, Varies§

Father's Name (Last, First Middle):

Father's Birth Date (mm-dd-yyyy):

§ If ordering MATCC or UNIPD, an order for MATCC or UNIPD must be placed on both the maternal and the fetal sample. Fetal and maternal samples must be sent under separate order numbers.

¶ The CYP21A2 Gene Testing for Congenital Adrenal Hyperplasia Patient Information Form (T663) is required for prenatal CYPZ orders; CYPZ testing will not be performed unless this form is also completed and sent with the sample.

§§ Also complete Familial Mutations section below.

† Also complete the test-specific patient information sheet located in the Lab Test Catalog.

# Molecular Genetics: Prenatal
# Patient Information (continued)

## Familial Mutation Testing (required patient information)

**Familial Mutations**

FMTT / Familial Variant, Targeted Testing, Varies cannot be performed without the information below.‡

Is the familial mutation a nucleotide substitution or small insertion/deletion of nucleotides? ☐ Yes ☐ No

If "Yes," provide the familial mutations here:

| | | | | |
|---|---|---|---|---|
| Mutation 1: | Gene | Exon/Intron | Nucleotide | Amino Acid |
| Mutation 2: | Gene | Exon/Intron | Nucleotide | Amino Acid |
| Mutation 3: | Gene | Exon/Intron | Nucleotide | Amino Acid |

Is the familial mutation a large deletion or duplication involving one or more exons? ☐ Yes ☐ No

If "Yes," provide the familial deletion/duplication here:

☐ Deletion ☐ Duplication

Gene: Exons:

**Familial History**

Include the name(s) and birth date(s) of the family member(s) who have had genetic testing (ie, proband):

Indicate the family member's relationship to the patient:

**Important: Attach a copy of the proband's genetic test result and a detailed pedigree, if available.**

‡**Note:** Analysis of regions surrounding the familial variant may be required and may result in the identification of additional sequence variants.

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