



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: 507-266-5700 / International clients: +1-507-266-5700 or email mcglobal@mayo.edu.**

Patient Information

Patient Name <i>(Last, First, Middle)</i>		Birth Date <i>(mm-dd-yyyy)</i>
Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Choose not to disclose		Legal/Administrative Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary

Referring Provider Information

Referring Provider Name <i>(Last, First)</i>	Phone	Email*	*Any communication sent via email will comply with applicable HIPAA regulations.
Genetic Counselor Name <i>(Last, First)</i>	Phone	Email*	

Reason for Testing

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Clinical Information

 Check all that apply.

Perinatal History <input type="checkbox"/> Prematurity <input type="checkbox"/> Intrauterine growth restriction (IUGR) <input type="checkbox"/> Oligohydramnios <input type="checkbox"/> Polyhydramnios <input type="checkbox"/> Abnormal prenatal testing (include copy of report) _____ <input type="checkbox"/> Other: _____ Growth <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Overgrowth <input type="checkbox"/> Short stature <input type="checkbox"/> Other: _____ Cognitive/Developmental <input type="checkbox"/> Developmental delay <input type="checkbox"/> Fine motor delay <input type="checkbox"/> Gross motor delay <input type="checkbox"/> Speech delay <input type="checkbox"/> Intellectual disability/MR <input type="checkbox"/> Learning disability <input type="checkbox"/> Other: _____ Behavioral/Psychiatric <input type="checkbox"/> ADHD <input type="checkbox"/> Autism <input type="checkbox"/> Oppositional-defiant disorder <input type="checkbox"/> Obsessive-compulsive disorder <input type="checkbox"/> Pervasive developmental delay <input type="checkbox"/> Other: _____ Cutaneous <input type="checkbox"/> Hyperpigmentation <input type="checkbox"/> Hypopigmentation <input type="checkbox"/> Other: _____	Neurological <input type="checkbox"/> Ataxia <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Encephalopathy <input type="checkbox"/> Hypotonia <input type="checkbox"/> Hypertonia <input type="checkbox"/> Seizures <input type="checkbox"/> Spasticity <input type="checkbox"/> Structural brain anomaly <input type="checkbox"/> Other: _____ Cardiac <input type="checkbox"/> Atrial septal defect <input type="checkbox"/> Atrioventricular (AV) canal defect <input type="checkbox"/> Tetralogy of Fallot <input type="checkbox"/> Ventricular septal defect <input type="checkbox"/> Other cardiac abnormality: _____ Craniofacial <input type="checkbox"/> Cleft lip <input type="checkbox"/> Cleft palate <input type="checkbox"/> Craniosynostosis <input type="checkbox"/> Dysmorphic features <input type="checkbox"/> Ear malformation <input type="checkbox"/> Macrocephaly <input type="checkbox"/> Microcephaly <input type="checkbox"/> Other: _____ Hearing/Vision <input type="checkbox"/> Abnormality of eye movement <input type="checkbox"/> Abnormality of vision <input type="checkbox"/> Hearing loss <input type="checkbox"/> Other: _____	Musculoskeletal <input type="checkbox"/> Club foot <input type="checkbox"/> Contractures <input type="checkbox"/> Diaphragmatic hernia <input type="checkbox"/> Limb anomaly <input type="checkbox"/> Polydactyly <input type="checkbox"/> Syndactyly <input type="checkbox"/> Vertebral anomaly <input type="checkbox"/> Other: _____ Gastrointestinal <input type="checkbox"/> Anal atresia <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Omphalocele <input type="checkbox"/> Pyloric stenosis <input type="checkbox"/> Tracheoesophageal fistula <input type="checkbox"/> Other: _____ Genitourinary <input type="checkbox"/> Ambiguous genitalia <input type="checkbox"/> Cryptorchidism <input type="checkbox"/> Hydronephrosis <input type="checkbox"/> Hypospadias <input type="checkbox"/> Kidney malformation <input type="checkbox"/> Other: _____ Family History <input type="checkbox"/> Parents with 2 or more miscarriages <input type="checkbox"/> Other relatives with similar clinical history (explain below): _____
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Clinical Descriptions

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

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