Complete and print.

MAYO CLINIC LABORATORIES

CYP21A2 Gene Testing for Congenital Adrenal Hyperplasia Patient Information

C Y P 2 1 A 2

Reset Form

Instructions: This form is intended to be completed by the ordering healthcare professional. Accurate interpretation and reporting of the genetic results is contingent upon the reason for testing, clinical information, ancestry, and family history. 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: Molecular Genetics 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 (required)

Patient Name (Last, First Middle)	Birth Date (mm-dd-yyyy)
Preferred Name	Medical Record Number (if Birth Date is not available)
Sex Assigned at Birth ☐ Male ☐ Female ☐ Choose not to disclose ☐ Other, specify:	Legal/Administrative Sex ☐ Male ☐ Female ☐ Nonbinary ☐ Choose not to disclose ☐ Other, specify:
Gender Identity (optional)	Pronouns (optional)
Ancestry: ☐ Unknown ☐ Choose not to disclose	

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.*

For diagnostic testing or carrier testing on whole blood or prenatal specimens, order CYPZ / 21-Hydroxylase Gene CYP21A2, Full Gene Analysis, Varies.

Note: • Due to the complexity of CYP21A2 testing, known variant testing is not available. If familial variants have been previously identified in this family, provide this information in the Family History section below and attach any available laboratory test reports from family members.

Reason for Testing

☐ Diagnosis or Suspected Diagnosis (Indicate relevant information in the Clinical History section below.)
☐ Prenatal (Indicate relevant information in the Clinical History section below.)
☐ Carrier Screening:
- ☐ Family history of the condition, specify:
- ☐ Partner has a family history of the condition
- ☐ Partner is a carrier of the condition
- ☐ Partner is affected with the condition
- ☐ Other reproductive risk assessment, specify:

Pertinent Clinical and Laboratory History Check all that apply.

☐ Suspected difference of sex development (such as clitoromegaly) detected on prenatal ultrasound
☐ Positive newborn screen for CAH (Congenital Adrenal Hyperplasia)
☐ Elevated 17-hydroxyprogesterone
☐ Chromosome analysis performed, indicate patient's results: ☐ 46, XX ☐ 46, XY ☐ Other, specify:
☐ History of salt-wasting
☐ Precocious puberty or virilization, specify:

Other Information (eg, specific prenatal findings):

Biological Family History

Are other biological relatives known to be affected? ☐ Yes ☐ No	If "Yes," indicate their biological relationship to the patient:
Are other biological relatives known to be a carrier? ☐ Yes ☐ No	If "Yes," indicate their biological relationship to the patient:
Have other relatives had molecular genetic testing? ☐ Yes ☐ No	If "Yes," indicate familial variants and attach a copy of the family member's lab report:
If the relative was tested at the Mayo Clinic, include the name of the family member:	

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).

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