

## CYP21A2 Gene Testing for Congenital Adrenal Hyperplasia Patient Information

C Y P 2 1 A 2

Instructions: 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: +1-507-266-5700 or email <a href="MLIINTL@mayo.edu">MLIINTL@mayo.edu</a>

Patient Information (required)					
Patient Name (Last, First Middle)			Birth Date (mm-dd-yyyy)		
Sex Assigned at Birth  Male Definition Female Unknown Choose not to disclose			Legal/Administrative Sex  ☐ Male ☐ Female ☐ Nonbinary		
Referring Provider Information					
Requesting Provider 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 regulation					
For diagnostic testing or carrier screening on whole  Note:  • Due to the complexity of CYP21A2 testing family, provide this information in the Fan  • For prenatal specimens, order CYPZ / 21-1	g, known variant te nily History section	esting is not avai n below and att	ilable. If familial var ach any available la	riants have bee aboratory test r	n previously identified in this
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 a □ Positive newborn screen for CAH (Congenital Adu □ Elevated 17-hydroxyprogesterone □ Chromosome analysis performed, indicate patier □ History of salt-wasting □ Precocious puberty or virilization, specify:	renal Hyperplasia)			pecify:	
Other Information (eg, specific prenatal findings)					
Ancestry Ancestry may assist with interpretation of	of test results.				
☐ African/African American ☐ East Asian ☐ Latino/Latina ☐ South Asian ☐ Unknown ☐ Ashkenazi Jewish ☐ European ☐ Middle Eastern ☐ None of the above ☐ Choose not to disclose					
Family History					
Are other relatives known to be affected?	☐ Yes ☐ No	If "Yes," indicat	te their relationship	to the patient	:
Are other relatives known to be a carrier?		If "Yes," indicate their relationship to the patient:			
		If "Yes," indicated lab report:	ate familial variants and attach a copy of the family member's		
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).