



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 mclglobal@mayo.edu.**

Patient Information

Patient Name <i>(Last, First, Middle)</i>	Birth Date <i>(mm-dd-yyyy)</i>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Provider Name <i>(Last, First)</i>	Phone	Fax*
Genetic Counselor Name <i>(Last, First)</i>	Phone	Fax*

*Fax number given must be from a fax machine that complies with applicable HIPAA regulations.

Reason for Testing

Clinical Information Check all that apply.

<p>Primary Indication for Testing</p> <ul style="list-style-type: none"> <input type="checkbox"/> Advanced maternal age <input type="checkbox"/> Fetal abnormality <input type="checkbox"/> Abnormal maternal serum screening <input type="checkbox"/> Abnormal cell-free DNA screening (NIPT, NIPS, cfDNA); increased risk for: _____ <p>Perinatal History</p> <ul style="list-style-type: none"> <input type="checkbox"/> 2 vessel cord <input type="checkbox"/> Donor egg or gestational carrier <input type="checkbox"/> Hydrops <input type="checkbox"/> Increased NT (includes cystic hygroma) <input type="checkbox"/> Intrauterine growth restriction (IUGR) <input type="checkbox"/> Oligohydramnios <input type="checkbox"/> Polyhydramnios <input type="checkbox"/> Other: _____ <p>Neurological</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormal gyri (lissencephaly) <input type="checkbox"/> Agenesis of the corpus callosum <input type="checkbox"/> Cerebellar hypoplasia <input type="checkbox"/> Dandy Walker <input type="checkbox"/> Decreased fetal movement <input type="checkbox"/> Holoprosencephaly <input type="checkbox"/> Neural tube defect <input type="checkbox"/> Structural brain anomaly <input type="checkbox"/> Ventriculomegaly/hydrocephaly <input type="checkbox"/> Other: _____ <p>Craniofacial</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cleft lip +/- palate <input type="checkbox"/> Macrocephaly <input type="checkbox"/> Microcephaly <input type="checkbox"/> Other: _____ 	<p>Cardiac</p> <ul style="list-style-type: none"> <input type="checkbox"/> Aortic atresia <input type="checkbox"/> Atrial septal defect <input type="checkbox"/> Atrioventricular (AV) canal defect <input type="checkbox"/> Coarctation of the aorta <input type="checkbox"/> Dextrocardia/situs inversus <input type="checkbox"/> Double outlet right ventricle <input type="checkbox"/> Ebstein anomaly <input type="checkbox"/> Echogenic intracardiac focus <input type="checkbox"/> Hypoplastic left heart <input type="checkbox"/> Hypoplastic right heart <input type="checkbox"/> Tetralogy of Fallot <input type="checkbox"/> Transposition of the great vessels <input type="checkbox"/> Truncus arteriosus <input type="checkbox"/> Ventricular septal defect <input type="checkbox"/> Other: _____ <p>Pulmonary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Congenital cystic adenomatoid malformation (CCAM)/small thoracic cavity <input type="checkbox"/> Diaphragmatic hernia <input type="checkbox"/> Pleural effusion <input type="checkbox"/> Pulmonary sequestration <input type="checkbox"/> Other: _____ <p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Absent stomach <input type="checkbox"/> Echogenic focus <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Meconium ileus/anal atresia <input type="checkbox"/> Omphalocele <input type="checkbox"/> Tracheoesophageal fistula <input type="checkbox"/> Other: _____ 	<p>Musculoskeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Acromelia <input type="checkbox"/> Clenched hands <input type="checkbox"/> Club foot <input type="checkbox"/> Contractures (arthrogryposis) <input type="checkbox"/> Limb anomaly <input type="checkbox"/> Mesomelia/micromelia <input type="checkbox"/> Polydactyly <input type="checkbox"/> Skeletal dysplasia <input type="checkbox"/> Syndactyly <input type="checkbox"/> Vertebral anomaly <input type="checkbox"/> Other: _____ <p>Genitourinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Ambiguous genitalia <input type="checkbox"/> Hydronephrosis kidney malformation <input type="checkbox"/> Megacystis (including posterior valves) <input type="checkbox"/> Polycystic kidneys <input type="checkbox"/> Renal agenesis <input type="checkbox"/> Urethra/ureter obstruction <input type="checkbox"/> Other: _____ <p>Family History</p> <ul style="list-style-type: none"> <input type="checkbox"/> Parents with 2 or more miscarriages <input type="checkbox"/> Other relatives with previous pregnancies with similar clinical history (explain below): _____ <input type="checkbox"/> Other: _____
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Clinical Descriptions Include any additional relevant clinical information (list karyotype if known and provide a report).