

**Instructions:** The accurate interpretation and reporting of the genetic results is contingent upon the reason for referral, clinical information, ethnic background, and family history. To help provide the best possible service, supply the information requested below and **send paperwork with the specimen, or return by fax to Mayo Clinic Laboratories, Attn: Personalized Genomics Laboratory Genetic Counselors at 507-284-1759. Phone: 507-266-5700 / International clients: +1-507-266-5700 or email [mclglobal@mayo.edu](mailto: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
Referring Provider Name <i>(Last, First)</i>	Phone	Fax*
Other Contact Name <i>(Last, First)</i>	Phone	Fax*

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

**Reason for Referral**

**Clinical History** Check all that apply.

Total cholesterol _____ mg/dL OR _____ mmol/L	Tendon xanthomas? <input type="checkbox"/> Yes <input type="checkbox"/> No
LDL cholesterol _____ mg/dL OR _____ mmol/L	Cutaneous xanthomas? <input type="checkbox"/> Yes <input type="checkbox"/> No
Sterol levels: Sitosterol _____ mg/dL Campesterol _____ mg/dL Other sterols _____ mg/dL	
History of coronary artery disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	History of myocardial infarction? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Information	

**Ethnic Background** Ethnic background may assist with interpretation of test results.

African American     Northern European Caucasian     Mixed European Caucasian     Middle Eastern  
 Asian     Southern European Caucasian     Hispanic  
 Other (specify): \_\_\_\_\_  
 Indicate countries of origin if available: \_\_\_\_\_

**Family History** Include a detailed pedigree, if available.

Is there a family history of young onset myocardial infarction (MI)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate the age at time of MI and relationship to the patient:
Is there a family history of high cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate the relationship to the patient:
Have other relatives been diagnosed with familial hypercholesterolemia or sitosterolemia? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe symptoms and indicate the relationship to the patient:
Have other relatives had molecular genetic testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate the performing laboratory and attach a copy of the genetic test lab report if available:
If the relative was tested at Mayo Clinic, include the name of the family member: _____	
<b>For known mutation test requests, order known variant analysis:</b> KVAR1 / Known Variant Analysis-1 Variant; KVAR2 / Known Variant Analysis-2 Variants; KVAR3 / Known Variant Analysis-3+ Variants	

**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).

Visit [www.MayoClinicLabs.com](http://www.MayoClinicLabs.com) for the most up-to-date test and shipping information.