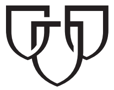

MAYO CLINIC LABORATORIES

Molecular Genetics: Congenital Inherited Diseases Patient Information

Instructions: The accurate interpretation and reporting of 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 this paperwork with the specimen or return by fax to Mayo Clinic Laboratories, Attn: Molecular Genetics Lab Genetic Counselors at 507-284-1759**.

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date *(mm-dd-yyyy)*	Gender ☐ Male ☐ Female
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 regulations.*

Reason for Testing

☐ **Carrier Screen** (Check the appropriate box.)

- ☐ Clinically normal individual with no family history of the condition
- ☐ Family history of the condition; if checked, complete Family History section
- ☐ Spouse has family history of the condition
- ☐ Spouse is a carrier of the condition
- ☐ Anonymous egg or sperm donor

☐ **Diagnosis or Suspected Diagnosis**

List all relevant clinical symptoms:

Ethnic Background

Ethnic background is necessary to provide appropriate interpretation of test results. Check the appropriate boxes. This is especially important for cystic fibrosis testing.

☐ African American	☐ Asian	☐ Hispanic	☐ Northern European Caucasian
☐ Ashkenazi Jewish	☐ French Canadian	☐ Mixed European Caucasian	☐ Southern European Caucasian
☐ Caucasian (indicate countries of origin): ______			☐ Other (specify): ______

Pregnancy Information

Is the patient or partner currently pregnant? ☐ Yes ☐ No If Yes, how many weeks gestation? ______

Family History

Are other relatives known to be affected? ☐ Yes ☐ No If Yes, indicate relationship to patient: ______

Are other relatives known to be carriers? ☐ Yes ☐ No If Yes, indicate relationship to patient: ______

Have other relatives had molecular genetic testing? ☐ Yes ☐ No If Yes, complete the information below:

Gene: ______

Name of individual tested *(Last, First, Middle)*: ______

Birth date of individual tested *(mm-dd-yyyy)*: ______

Mutations: ______

Laboratory at which testing was performed: ______

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