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MAYO CLINIC LABORATORIES

Molecular Genetics: Inherited Cancer Syndromes 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 provided must be from a fax machine that complies with applicable HIPAA regulations.*

Reason for Testing

Study Purpose ☐ Diagnostic ☐ Presymptomatic

If more than one test is ordered, should all tests be performed at the same time? ☐ Yes ☐ No

If no, indicate preferred order of testing: _____

Note: If a multigene panel is ordered, sequencing and array/multiplex ligation-dependent probe amplification (MLPA) tests for all genes will be performed at the same time.

Ethnic Background

☐ European Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other (specify): _____

Clinical Information (check all that apply)

Polyps? ☐ Yes ☐ No ☐ Unknown/Not Screened

Number: ☐ 0 polyps ☐ 1–5 ☐ 6–20 ☐ 21–50 ☐ 51–100 ☐ More than 500

Location: | Histopathology:

Cancer

☐ Colon ☐ Endometrial ☐ Gastric ☐ Breast ☐ Ovarian ☐ Pancreatic ☐ Brain
☐ Upper tract urothelial ☐ Sarcoma ☐ Adrenocortical carcinoma ☐ Leukemia/Lymphoma
☐ Thyroid, specify type: _____ ☐ Other, specify: _____

Dermatological features? ☐ Yes ☐ No If yes, describe: _____

Other Manifestations

☐ Congenital hypertrophy of retinal pigment epithelium ☐ Fibrocystic disease ☐ Macrocephaly ☐ Pheochromocytoma
☐ Desmoid tumors ☐ Ganglioneuromas ☐ Oligodontia ☐ Sertoli cell or sex cord tumors
☐ Epidermoid cysts ☐ Hyperparathyroidism ☐ Osteomas ☐ Telangiectasias
☐ Other, specify: _____ ☐ Lhermitte-Duclos disease ☐ Overgrowth ☐ Uterine fibroids

Has previous testing been performed for this patient? ☐ Yes ☐ No If yes, complete information below:

☐ Sequencing for genes: _____

☐ Deletion/duplication for genes: _____

Has microsatellite instability/immunohistochemistry (MSI/IHC) been performed? ☐ Yes ☐ No

If yes, describe: _____

Family History

Are other relatives known to be affected? ☐ Yes ☐ No If yes, relationship to the patient: _____

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

Gene: _____ Name and birth date of individual tested: _____

Mutations: _____ Laboratory at which testing was performed: _____

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