



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**

Patient Information

Patient Name <i>(Last, First, Middle)</i>	Birth Date <i>(mm-dd-yyyy)</i>	Sex <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.

Is this a postmortem specimen? Yes No If yes, attach autopsy report if available.

Clinical History

Reason for Testing (check all that apply): Diagnosis Carrier testing Presymptomatic diagnosis Family history Sudden death
Note: Genetic testing should always be initiated on an affected family member first, if possible, in order to be most informative for at-risk relatives. See Ethnic Background and Family History section for more information.

Diagnosis/Suspected Diagnosis:
 Noonan syndrome Cardiofaciocutaneous (CFC) syndrome Costello syndrome Multiple Lentigines (LEOPARD) syndrome
 Other (specify): _____

Indicate whether the following are present.

Cardiovascular:
 Pulmonary valve stenosis Pulmonary artery stenosis Atrial septal defect Ventricular septal defect
 Hypertrophic cardiomyopathy Tetralogy of Fallot EKG abnormality Aortic coarctation
 Other (specify): _____

Skeletal:
 Short stature Pectus abnormality Scoliosis Cubitus valgus Vertebral anomalies

Facial dysmorphism:
 Characteristic Noonan facies (hypertelorism, epicanthal folds, ptosis, down-slanting palpebral fissures, triangular facies, low-set, posteriorly rotated ears, light-colored irises)
 Characteristic CFC syndrome/Costello facies (macrocephaly, coarse facial features including full lips, large mouth)

Developmental:
 Developmental delay Mental retardation Attention deficit/hyperactivity disorder

Cutaneous:
 Lentigines Café-au-lait spots Hyperkeratosis Ichthyosis Eczema Pigmented moles
 Hyperkeratosis Dystrophic nails Deep palmar and plantar creases

Hair abnormalities:
 Sparse Curly Fine Thick Woolly Brittle Absent eyebrows/eyelashes Loose anagen hair

Additional features:
 Hearing loss Broad or webbed neck with low posterior hairline Cryptorchidism Low-set nipples
 Feeding difficulties Postnatally reduced growth Coagulation defects Lymphatic dysplasia
 Malignancy/Tumor/Leukemia (specify): _____

List any additional features present:

Ethnic Background and Family History

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

Are other relatives known to be affected? Yes No
 If yes, indicate their diagnosis and relationship to the patient: _____

Have other relatives had molecular genetic testing? Yes No

For known mutation test requests, order known variant analysis:
 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), Informed Consent for Genetic Testing – Spanish (T826), or Informed Consent for Genetic Testing for Deceased Individuals (T782).