Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Viral Susceptibility, Lymphoproliferation, and Hemophagocytic Lymphohistiocytosis Patient Information

Instructions: This form is intended to be completed by the ordering healthcare professional. Accurate interpretation and reporting of genetic results is contingent upon the reason for testing, clinical information, biological family history, and ancestry. 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: Molecular Technologies Laboratory Genetic Counselors at 507-284-1759. Phone: 800-533-1710 / International clients: 855-379-3115 or +1-507-284-9273, or email mliintl@mayo.edu.**

Patient Information

Patient Name (Last, First Middle)		Birth Date (mm-dd-yyyy)
Preferred Name	Medical Record Number (if Birth Date is not available)	
Sex Assigned at Birth ☐ Male ☐ Female ☐ Choose not to disclose ☐ Other, specify:	Legal/Administrative Sex ☐ Male ☐ Female ☐ Nonbinary ☐ Choose not to disclose ☐ Other, specify:	
Gender Identity (optional)	Pronouns (optional)	

Referring Healthcare Professional Information

Referring Healthcare Professional 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.

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

Reason for Testing Specify below or attach relevant clinic note.

☐ Confirm clinical diagnosis; specify diagnosis: Age of onset:

☐ Biological family history**; describe:

☐ Other; specify:

**Genetic testing should be performed on an affected biological family member first, when available. FMTT / Familial Variant, Targeted Testing should be ordered when there is a previous positive genetic test result in the family.

Clinical Presentation

☐ Epstein Barr Virus (EBV) susceptibility:

☐ Other viral susceptibility; specify:

☐ Lymphoproliferative disorder

☐ Familial hemophagocytic lymphohistiocytosis (F-HLH)

☐ Other; specify:

Clinical Features Check all that apply.

☐ Brainstem encephalitis	☐ Hemophagocytosis	☐ Pityriasis-like lesions
☐ Coagulopathy/Thrombophilia	☐ Herpes simplex encephalitis	☐ Severe influenza pneumonia
☐ Critical COVID-19 pneumonia	☐ Hyperpigmentation/Hypopigmentation	☐ Severe mononucleosis
☐ Disseminated intravascular coagulation	☐ Hypogammaglobulinemia	☐ Splenomegaly
☐ Epidermodysplasia verruciformis	☐ Live-attenuated viral vaccine strain disease	☐ Varicella zoster virus encephalitis and cerebellitis
☐ Fever	☐ Lymphoproliferation	☐ Warts
☐ Fulminant viral hepatitis	☐ Neurological symptoms	☐ Other; specify:

Viral Susceptibility, Lymphoproliferation, and Hemophagocytic Lymphohistiocytosis Patient Information (continued)

Oncologic History

Note: Skin biopsy is the preferred specimen type to detect germline variants in patients with active hematological malignancy.

- ☐ Myelodysplasia/AML
- ☐ Lymphoma; specify:
- ☐ Solid tumor; specify:
- ☐ Leukemia; specify:
- ☐ Skin cancer; specify:
- ☐ Other; specify:

Patient Treatment History

Has the patient received an allogenic stem cell transplant***? ☐ No ☐ Yes; transplant date (mm-dd-yyyy):

Is the patient transfusion-dependent***? ☐ No ☐ Yes; last transfusion date (mm-dd-yyyy):

Was this transfusion leukoreduced***? ☐ No ☐ Yes ☐ Unknown

Chemotherapy: ☐ No ☐ Yes; date (mm-dd-yyyy): _____

***Results may be inaccurate due to the presence of donor DNA if the patient has received an allogeneic hematopoietic stem cell transplant or non-leukocyte reduced blood products. Call Mayo Clinic Laboratories for instructions for testing patients who have received a bone marrow transplant.

General History

- ☐ Anemia (Hemoglobin < 9 g/dL; neonates < 10 g/dL)
- ☐ Thrombocytopenia (Platelets < 100 × 10^9/L)
- ☐ Neutropenia (Neutrophils < 1 x 10^9/L)
- ☐ Hypertriglyceridemia (≥ 265 mg/dL; ≥ 3 mmol/L)
- ☐ Hypofibrinogenemia (≤ 150 mg/dL; ≤ 1.5 g/L)
- ☐ Hyperferritinemia (≥ 500 mg/nL; ≥ 500 µg/L)
- ☐ Reduced or absent NK-cell cytotoxicity
- ☐ Elevated soluble CD25 (soluble IL-2 receptor)
- ☐ Viral infection; specify:
- ☐ Other infections; specify:

Biological Family History

Are there similarly affected biological relatives? ☐ Yes ☐ No

If "Yes," indicate relationship, and diagnosis or symptoms:

Have any biological family members had genetic testing? ☐ Yes**** ☐ No ☐ Unknown

****FMTT / Familial Variant, Targeted Testing should be ordered when there is a previous positive genetic test result in the family. Contact the lab for ordering assistance.

History of consanguinity

☐ No ☐ Unknown ☐ Choose not to disclose ☐ Yes; biological relationship details:

Patient Ancestry

Ancestry: ☐ Unknown ☐ Choose not to disclose

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).

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