Complete and print.

MAYO CLINIC LABORATORIES

Familial/Autosomal Dominant Hypercholesterolemia Patient Information

F A D H P T I N

Reset Form

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 MLIINT@mayo.edu**

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date *(mm-dd-yyyy)*	Sex ☐ Male ☐ Female
Referring Provider Name *(Last, First)*	Phone	Fax*
Other Contact Name *(Last, First)*	Phone	Fax*

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

Reason for Testing

Clinical History Check all that apply.

Total cholesterol _____ mg/dL OR _____ mmol/L	Tendon xanthomas? ☐ Yes ☐ No
Low density cholesterol _____ mg/dL OR _____ mmol/L	Cutaneous xanthomas? ☐ Yes ☐ No
Sterol levels: Sitosterol _____ mg/dL Campesterol _____ mg/dL Other sterols _____ mg/dL	
History of coronary artery disease? ☐ Yes ☐ No	History of myocardial infarction? ☐ Yes ☐ No
Other Information	

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

☐ African American ☐ Hispanic ☐ Mixed European ☐ Southern European
☐ Asian ☐ Middle Eastern ☐ Northern European ☐ 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)? ☐ Yes ☐ No	If Yes, indicate the age at time of MI and relationship to the patient:
Is there a family history of high cholesterol? ☐ Yes ☐ No	If Yes, indicate the relationship to the patient:
Have other relatives been diagnosed with familial hypercholesterolemia or sitosterolemia? ☐ Yes ☐ No	If Yes, describe symptoms and indicate the relationship to the patient:
Have other relatives had molecular genetic testing? ☐ Yes ☐ 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: _____	
For familial variant (site-specific) testing, order FMTT / Familial Mutation Targeted Testing, Varies and attach documentation of the specific familial variant/mutation to be tested.	

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 for the most up-to-date test and shipping information.

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