



Instructions: Accurate interpretation and reporting of genetic results is contingent upon the reason for testing, clinical information, ethnic background/ancestry, 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: Molecular Technologies Laboratory Genetic Counselors at 507-284-1759. Phone: 800-533-1710 / International clients: +1-507-266-5700 or email MLIINT@mayo.edu**

Patient Information

Patient Name <i>(Last, First, Middle)</i>		Birth Date <i>(mm-dd-yyyy)</i>
Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Choose not to disclose	Legal/Administrative Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary	

Referring Provider Information

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.*

Reason for Testing

Diagnosis Family History** Other, specify: _____

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

Indications

Familial hypercholesterolemia Hypertriglyceridemia Hypobetalipoproteinemia Familial lipodystrophy Sitosterolemia

Clinical History

<p>Laboratory Findings</p> <p>Cholesterol</p> <ul style="list-style-type: none"> Total cholesterol: _____ mg/dL OR _____ mmol/L Low density cholesterol (LDL): _____ mg/dL OR _____ mmol/L High density cholesterol (HDL): _____ mg/dL OR _____ mmol/L Triglycerides: _____ mg/dL OR _____ mmol/L <p>Sterols</p> <ul style="list-style-type: none"> Sitosterol: _____ mg/dL Campesterol: _____ mg/dL Other sterols: _____ 	<p>Clinical Findings</p> <ul style="list-style-type: none"> <input type="checkbox"/> Tendon xanthomas <input type="checkbox"/> Cutaneous xanthomas <input type="checkbox"/> History of coronary artery disease <input type="checkbox"/> History of myocardial infarction <input type="checkbox"/> Lipodystrophy <ul style="list-style-type: none"> <input type="checkbox"/> Generalized <input type="checkbox"/> Partial <input type="checkbox"/> Insulin resistance/Diabetes <input type="checkbox"/> Non-alcoholic liver disease <input type="checkbox"/> Kidney failure
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Other Relevant Clinical History

Hereditary Dyslipidemia Patient Information (continued)

Patient Name (Last, First, Middle)	Birth Date (mm-dd-yyyy)
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Family History

Are there similarly affected relatives? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," indicate relationship and symptoms: _____
Have any family member had genetic testing? <input type="checkbox"/> Yes*** <input type="checkbox"/> No <input type="checkbox"/> Unknown ***FMTT / Familial Mutation 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: <input type="checkbox"/> No <input type="checkbox"/> Yes; relationship details: _____

Ancestry

<input type="checkbox"/> African/African American	<input type="checkbox"/> East Asian	<input type="checkbox"/> Latinx/Latine	<input type="checkbox"/> South Asian	<input type="checkbox"/> Choose not to disclose
<input type="checkbox"/> Ashkenazi Jewish	<input type="checkbox"/> European	<input type="checkbox"/> Middle Eastern	<input type="checkbox"/> None of the above	<input type="checkbox"/> Unknown

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).