Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Molecular Genetics: Congenital Inherited Diseases Patient Information

Instructions: The accurate interpretation and reporting of genetic results is contingent upon the reason for testing, 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)*

Sex Assigned at Birth	Legal/Administrative Sex
☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose	☐ Male ☐ Female ☐ Nonbinary

Referring Provider Information

Referring Provider 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.*

Reason for Testing

☐ **Carrier Screen** (Check the appropriate box.)

- ☐ Clinically normal individual with no family history of the condition
- ☐ Family history of the condition; if checked, complete Family History section
- ☐ Spouse has family history of the condition
- ☐ Spouse is a carrier of the condition
- ☐ Anonymous egg or sperm donor

☐ **Diagnosis or Suspected Diagnosis**

List all relevant clinical symptoms:

Ethnic Background

Ethnic Background Ethnic background is necessary to provide appropriate interpretation of test results. Check the appropriate boxes. This is especially important for cystic fibrosis testing.

☐ African American	☐ Asian	☐ Hispanic	☐ Northern European
☐ Ashkenazi Jewish	☐ French Canadian	☐ Mixed European	☐ Southern European
☐ Caucasian; indicate countries of origin:			☐ Other, specify:

Pregnancy Information

Is the patient or partner currently pregnant? ☐ Yes ☐ No If Yes, how many weeks gestation?

Family History

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

Are other relatives known to be carriers? ☐ Yes ☐ No If Yes, indicate relationship to patient:

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

Gene:

Name of individual tested *(Last, First, Middle)*:

Birth date of individual tested *(mm-dd-yyyy)*:

Mutations:

Laboratory at which testing was performed:

Print