Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Malignant Hyperthermia and Pseudocholinesterase Deficiency Patient Information

Instructions: The accurate interpretation and reporting of 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 this paperwork with the specimen**.

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date *(mm-dd-yyyy)*	Gender ☐ Male ☐ Female
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

Select one or more of the following indications for testing:

☐ Diagnosis/Suspected diagnosis ☐ Carrier testing

☐ Malignant hyperthermia susceptibility ☐ Pseudocholinesterase deficiency

☐ Other (specify): _____

Ethnic Background

☐ African American ☐ Asian ☐ European Caucasian ☐ Hispanic/Latino ☐ Middle Eastern

☐ Other (specify): _____

Indicate country of origin: _____

Clinical Information

Does the patient have history of exposure to any of the following anesthetic agents? Check all that apply.

☐ Desflurane ☐ Enflurane ☐ Halothane ☐ Isoflurane ☐ Sevoflurane ☐ Mivacurium ☐ Succinylcholine

☐ Other (specify): _____

Did the patient experience any of the following in response to anesthesia, mivacurium, or succinylcholine? Check all that apply.

☐ Malignant hyperthermia ☐ Prolonged paralysis

☐ Other adverse reaction (describe): _____

Does the patient have a history of rhabdomyolysis in response to any of the following? Check all that apply.

☐ Intense exercise in hot conditions ☐ Neuroleptic drugs ☐ Alcohol ☐ Infections

Provide the following, if applicable:

In vivo muscle contracture testing performed ☐ Yes ☐ No Results: _____

Total pseudocholinesterase: _____ U/L Reference range: _____ Dibucaine inhibition: _____ %

Additional Comments: _____

Family History

Has a family member experienced malignant hyperthermia with anesthesia? ☐ Yes ☐ No

Has a family member experienced prolonged paralysis from mivacurium or succinylcholine? ☐ Yes ☐ No

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

Have other relatives had molecular genetic testing? ☐ Yes ☐ No If yes, indicate the following:

Performing laboratory at which testing was performed: _____

Variants detected in relative: _____

If relative was tested at Mayo Clinic:

Relative name *(Last, First, Middle)*: _____

Relationship to patient: _____

Attach a copy of the genetic test lab report, if available.

Print