Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Hemophilia B Patient Information

The accurate interpretation and reporting of genetic results is contingent upon the reason for testing, clinical information, 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 507-284-1759**.

†Contact the Special Coagulation DNA Laboratory at 800-533-1710 with questions (International Clients +1-507-266-5700 or mclglobal@mayo.edu).

Patient Information

Patient Name *(Last, First, Middle)*		Birth Date *(mm-dd-yyyy)*
Sex Assigned at Birth ☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose	Legal/Administrative Sex ☐ Male ☐ Female ☐ Nonbinary	

Referring Provider Information

Requesting 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 Check one.

☐ Patient has a diagnosis or suspected diagnosis of hemophilia B and you would like to identify the underlying mutation.

☐ Patient has a family history of hemophilia B.

☐ Patient is a known or suspected carrier for hemophilia B, and the mutation in the family has not been previously identified.
If familial mutation has been identified, indicate it in the F9 Known Mutation box.

F9 Known Mutation

If FMTT / Familial Mutation, Targeted Testing, Varies is ordered, the following information MUST be provided or testing cannot be completed:

Known familial mutation:

Proband's relationship to patient:

Clinical Information

Factor 9 Coagulant Activity

☐ Undetermined or unavailable
☐ Less than 1% of normal (severely affected)
☐ 1%–5% of normal (moderately affected†)
☐ More than 5% of normal (mildly affected†)

Indicate any other relevant clinical information:

Pregnancy Information

Is patient or partner currently pregnant? ☐ Yes ☐ No If Yes, weeks gestation:

Prenatal specimen? ☐ Yes ☐ No If Yes, specify specimen type: ☐ Chorionic villus sampling ☐ Amniotic fluid

Cord blood specimen? ☐ Yes ☐ No

Family History

Are there relatives known to be affected or to be a carrier of hemophilia B? ☐ Yes ☐ No ☐ Unknown
If Yes, indicate relationship (including degree) to patient or attach pedigree:

Have other relatives had molecular genetic testing for hemophilia B? ☐ Yes ☐ No ☐ Unknown
If Yes, provide results and attach a copy of the genetic test lab report, if available:

If the relative was tested at Mayo Clinic, include the following information about the family member:

Name *(Last, First, Middle)* Birth Date *(mm-dd-yyyy)*

Affiliation

Hemophilia Center Affiliation
☐ Yes ☐ No If Yes, which center:

Print