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Reset Form

MAYO CLINIC LABORATORIES

Viral Susceptibility, Lymphoproliferation, and Hemophagocytic Lymphohistiocytosis Patient Information

Instructions: Accurate interpretation and reporting of genetic results is contingent upon the reason for testing, clinical information, family history, and ancestry. 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 800-533-1710. 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 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 Specify below or attach relevant clinic note.

☐ Confirm clinical diagnosis; specify diagnosis: Age of onset:

☐ Family history**; describe:

☐ Other; specify:

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

Clinical Presentation

☐ Epstein Barr Virus (EBV) susceptibility

☐ Other viral susceptibility; specify:

☐ Lymphoproliferative disorder

☐ Familial hemophagocytic lymphohistiocytosis (F-HLH)

☐ Other; specify:

Clinical Features Check all that apply.

☐ Abnormal bleeding
☐ Abnormal pigmentation
☐ Brainstem encephalitis
☐ Critical COVID-19 pneumonia
☐ Disseminated intravascular coagulation
☐ Epidermodysplasia verruciformis
☐ Fever
☐ Fulminant viral hepatitis
☐ Hemophagocytosis
☐ Herpes simplex encephalitis
☐ Hypogammaglobulinemia
☐ Live-attenuated viral vaccine strain disease
☐ Lymphoproliferation
☐ Neurological symptoms
☐ Pityriasis-like lesions
☐ Severe influenza pneumonia
☐ Severe mononucleosis
☐ Splenomegaly
☐ Varicella zoster virus encephalitis and cerebellitis
☐ Warts
☐ Other; specify:

Oncologic History

☐ Myelodysplasia/AML
☐ Lymphoma; specify:
☐ Solid tumor; specify:
☐ Leukemia; specify:
☐ Skin cancer; specify:
☐ Other; specify:

Viral Susceptibility, Lymphoproliferation, and Hemophagocytic Lymphohistiocytosis Patient Information (continued)

Patient Treatment History

Has the patient received an allogenic stem cell transplant***? ☐ No ☐ Yes; transplant date *(mm-dd-yyyy)*:

Is the patient transfusion-dependent***? ☐ No ☐ Yes; last transfusion date *(mm-dd-yyyy)*:

Was this transfusion leukoreduced***? ☐ No ☐ Yes ☐ Unknown

Chemotherapy: ☐ No ☐ Yes; date *(mm-dd-yyyy)*:

***Results may be inaccurate due to the presence of donor DNA if the patient has received an allogeneic hematopoietic stem cell transplant or non-leukocyte reduced blood products. Call Mayo Clinic Laboratories for instructions for testing patients who have received a bone marrow transplant.

General History

☐ Anemia (Hemoglobin < 9 g/dL; neonates < 10 g/dL)	☐ Hyperferritinemia (≥ 500 mg/nL; ≥ 500 µg/L)
☐ Thrombocytopenia (Platelets < 100 × 10^9/L)	☐ Reduced or absent NK-cell cytotoxicity
☐ Neutropenia (Neutrophils < 1 x 10^9/L)	☐ Elevated soluble CD25 (soluble IL-2 receptor)
☐ Hypertriglyceridemia (≥ 265 mg/dL; ≥ 3 mmol/L)	☐ Viral infection; specify:
☐ Hypofibrinogenemia (≤ 150 mg/dL; ≤ 1.5 g/L)	☐ Other infections; specify:

Family History

Are there similarly affected relatives? ☐ Yes ☐ No

If "Yes," indicate relationship, and diagnosis or symptoms:

Have any family members had genetic testing? ☐ Yes**** ☐ No ☐ 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: ☐ No ☐ Yes; relationship details:

Ancestry

☐ African/African American	☐ East Asian	☐ Latinx/Latine	☐ South Asian	☐ Unknown
☐ Ashkenazi Jewish	☐ European	☐ Middle Eastern	☐ None of the above	☐ Choose not to disclose

New York State patients: Informed Consent for Genetic Testing is required. See Informed Consent for Genetic Testing (T576), Informed Consent for Genetic Testing – Spanish (T826), or Informed Consent for Genetic Testing for Deceased Individuals (T782).

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