Complete and print.

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MAYO CLINIC LABORATORIES

Primary Ciliary Dyskinesia Genetic Testing Patient Information

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 *(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

Referring 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

☐ 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.

Clinical History

Clinical Findings

☐ Situs abnormality
- ☐ Situs inversus totality
- ☐ Heterotaxy
- ☐ Dextrocardia/Congenital heart defect
- ☐ Asplenia/Polysplenia
- ☐ Pulmonary isomerism
- ☐ Other, specify:

☐ Chronic nasal congestion
☐ Chronic sinusitis
☐ Pulmonary disease
- ☐ Neonatal respiratory distress
- ☐ Chronic airway infections
- ☐ Bronchiectasis
- ☐ Pulmonary calcium deposits

☐ Chronic or recurrent ear infections
☐ Infertility

Laboratory Findings

☐ Abnormal ciliary ultrastructure
- ☐ Shortening/Absence of outer dynein arms
- ☐ Shortening/Absence of both outer and inner dynein arms
- ☐ Microtubular disorganization
- ☐ Absence/Disruption of the central apparatus
- ☐ Other, specify:

☐ Abnormal ciliary motility
☐ Low nasal nitric oxide: nl/min

Other Relevant Clinical History

Family History

Are there similarly affected relatives? ☐ Yes ☐ No

If "Yes," indicate relationship and symptoms:

Have any family member 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) or Informed Consent for Genetic Testing – Spanish (T826).

Print