Please complete, print and submit. Reset Form

MAYO CLINIC
Mayo Medical Laboratories

Biochemical Genetics Patient Information

Complete all information below. **Send paperwork with the specimen or return by fax to MML Biochemical Genetics Laboratory 507-266-2888.**
For questions or additional assistance, phone 800-533-1710 and ask for the on-call Biochemical Genetics Counselor.

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date *(Month DD, YYYY)*	Gender ☐ Male ☐ Female
Referring Physician *(Last, First)*	Phone	Fax
Genetics Counselor *(Last, First)*	Phone	Fax

**Fax number given must be from a fax machine that complies with applicable HIPAA regulations.*

Specimen Information

Today's Date *(Month DD, YYYY)*	Collection Date *(Month DD, YYYY)*

☐ Repeat specimen ☐ Follow up to: _____ ☐ Postmortem

Reason for Testing (Do not use this form for prenatal testing)

☐ Positive Newborn Screen for: _____ ☐ Rule out: _____

☐ Monitor Treatment: _____ ☐ Family History: _____ ☐ Carrier Screening: _____

Clinical Information

Please list all relevant clinical information and the results of any applicable testing (screening and diagnostic).

☐ Current acute illness ☐ Chronic symptoms ☐ Intermittent symptoms, currently well

Current Medications/Diet: _____

If for carrier screening, were oral contraceptives used? ☐ Yes ☐ No

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

Family History

Ethnic background (patient): _____

Are there any other individuals diagnosed with or suspected of having this condition? ☐ Yes ☐ No

Please list all relevant clinical information and the results of any applicable testing (screening and diagnostic) for each individual and include whether they are living or deceased:

Print

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