

Accurate interpretation and reporting of genetic results is contingent upon receiving information on the reason for referral, ethnic background of patient, and family history. Supply information requested below and send paperwork with the specimen or return by fax 507-284-8286.

* Contact the Special Coagulation DNA Laboratory at 800-533-1710. **International clients:** + 1 507 266 5700 or email mmjglobal@mayo.edu

Patient Information

Patient Name <i>(Last, First, Middle I.)</i>	Birth Date <i>(Month DD, YYYY)</i>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Referring Physician <i>(Last, First)</i>	Phone	Fax*
Other Contact	Phone	Fax*

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

Affiliation

Hemophilia Center Affiliation:
 No Yes If yes, which center: _____

F8 Known Mutation (if applicable)

If a known mutation is ordered, the following information must be provided or testing cannot be completed.
 Known familial mutation:
 Intron 1 Inversion
 Intron 22 Inversion
 Other: _____

Proband's relationship to this patient: _____

Testing Reason

Patient has a diagnosis or suspected diagnosis of Hemophilia A and you would like to identify the underlying mutation.
 Patient has a family history of Hemophilia A.
 Patient is a known or suspected carrier for Hemophilia A. If familial mutation has been identified indicate it in the Known Mutation box.

Pregnancy Information

Is patient or partner currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, weeks gestation _____	Prenatal specimen? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify specimen type: <input type="checkbox"/> CVS <input type="checkbox"/> AF Cord blood specimen? <input type="checkbox"/> No <input type="checkbox"/> Yes
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Clinical Information

Factor VIII Coagulant Activity <input type="checkbox"/> Undetermined or unavailable <input type="checkbox"/> Less than 1% of normal (severely affected) <input type="checkbox"/> 1-5% of normal (moderately affected*) <input type="checkbox"/> More than 5% of normal (mildly affected*)	Indicate any other relevant clinical information:
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Family History

Are there relatives known to be affected or to be a carrier of Hemophilia A?
 No Unknown Yes Indicate relationship (including degree) to patient or attach pedigree.

Have other relatives had molecular genetic testing for Hemophilia A?
 No Unknown 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 name and birth date of the family member.