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MAYO CLINIC
Mayo Medical Laboratories

Hereditary Cardiomyopathies and Arrhythmias: Patient Information

H C A P T I N

Instructions: The accurate interpretation and reporting of the genetic results is contingent upon the reason for referral, clinical information, ethnic background, and family history. Supply the information requested below and send this paperwork with the specimen.

Patient Information (required)

Patient ID *(Medical Record Number)*	Patient Name *(Last, First, Middle)*		
Gender ☐ Male ☐ Female	Birth Date *(Month DD, YYYY)*	Collection Date *(Month DD, YYYY)*	Time ☐ a.m. ☐ p.m

Submitting Physician/Physician Name Information (required)

Submitting/Referring Physician *(Last, First)*	☐ Phone ( ) _____ – _____ ☐ Fax* ( ) _____ – _____

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

Client History — Attach Medical Records/Diagnostic Tests

Reason for Testing (check all that apply)

☐ Diagnosis ☐ Carrier testing ☐ Presymptomatic diagnosis ☐ Family history

Note: Genetic testing should always be initiated on an affected family member first, when available, in order to be most informative for at-risk relatives.

Diagnosis (check all that apply)

Is this patient affected? ☐ Yes ☐ No

☐ HCM ☐ DCM ☐ ARVC ☐ LVNC ☐ Other cardiomyopathy _____

☐ CPVT ☐ Brugada ☐ Long QT ☐ Other arrhythmia _____

☐ Other _____

Age at diagnosis _____

Has patient had:

Sudden cardiac arrest ☐ Yes ☐ No Describe: _____

Syncope ☐ Yes ☐ No Describe: _____

ARVC: RV fatty infiltration ☐ Yes ☐ No

Arrhythmia: Maximum QTc interval: _____ msec

Conduction system disease ☐ Yes ☐ No Describe: _____

Cardiomyopathy:

LV hypertrophy ☐ Yes ☐ No Maximum LV wall thickness: _____ mm

LV Dilation ☐ Yes ☐ No LV internal diameter, diastole: _____ mm

Ejection fraction: _____%

Other Relevant Information:

Next Page

Patient Information (required)

Patient ID (Medical Record Number)	Patient Name *(Last, First, Middle)*	Birth Date *(Month DD, YYYY)*

Ethnic Background and Family History - Attach pedigree if available

☐ European Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other *(specify)* _____

Are other relatives known to be affected ☐ Yes ☐ No If Yes, indicate their relationship to the patient to be affected? _____

Have other relatives had molecular genetic testing? ☐ Yes ☐ No

Other Relevant Information:

New York State Patients: Informed Consent for Genetic Testing is required. See Informed Consent for Genetic Testing (Supply T576).

Ship specimens to:
Mayo Medical Laboratories
3050 Superior Drive NW
Rochester, MN 55901

Customer Service: 855-516-8404

Billing Information
- An itemized invoice will be sent each month.
- Payment terms are net 30 days.

Call the Business Office with billing related questions:
800-447-6424 (US and Canada)
507-266-5490 (outside the US)

Visit www.MayoMedicalLaboratories.com for the most up-to-date test and shipping.

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