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MAYO CLINIC
Mayo Medical Laboratories

Molecular Genetics: Inherited Cancer Syndromes Patient Information

The accurate interpretation and reporting of genetic results is contingent upon the reason for referral, clinical information, ethnic background, and family history. To help provide the best possible service, supply the information requested below and **send this paperwork with the specimen or return by fax to the Molecular Genetics Laboratory 507-284-0670.**

Patient Information

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

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

Reason for Testing

Study Purpose: ☐ Diagnostic ☐ Presymptomatic

If more than one test is ordered, should all tests be performed at the same time? ☐ No ☐ Yes
If no, indicate preferred order of testing: _____

Note: If a multigene panel is ordered, sequencing and array/MLPA tests for all genes will be performed at the same time.

Clinical History (check all that apply)

Polyps ☐ No ☐ Yes ☐ Unknown/Not Screened
Number ☐ 0 polyps ☐ 1-5 ☐ 6-20 ☐ 21-50 ☐ 51-100 ☐ More than 500

Location: | Histopathology:

Cancer
☐ Colon ☐ Endometrial ☐ Gastric ☐ Breast ☐ Ovarian ☐ Pancreatic ☐ Brain
☐ Upper Tract Urothelial ☐ Sarcoma ☐ Adrenocortical Carcinoma ☐ Leukemia/Lymphoma
☐ Thyroid, specify type _____ ☐ Other, specify _____

Dermatological features? ☐ No ☐ Yes If yes, describe _____

Other Manifestations
☐ CHRPE ☐ Fibrocystic Disease ☐ Macrocephaly ☐ Pheochromocytoma
☐ Desmoid Tumors ☐ Ganglioneuromas ☐ Oligodontia ☐ Sertoli Cell or Sex Cord Tumors
☐ Epidermoid Cysts ☐ Hyperparathyroidism ☐ Osteomas ☐ Telangiectasias
☐ Lhermitte-Duclos Disease ☐ Overgrowth ☐ Uterine Fibroids
☐ Other, specify _____

Has previous testing been performed for this patient? ☐ No ☐ Yes If yes, complete information below:
☐ Sequencing for genes _____
☐ Deletion/duplication for genes _____
Has MSI/IHC been performed? ☐ No ☐ Yes If yes, describe _____

Family History

Are other relatives known to be affected? ☐ No ☐ Yes If yes, indicate their relationship to the patient: _____
Have other relatives had molecular genetic testing? ☐ No ☐ Yes If yes, complete the information below:
Gene: _____ Name and date of birth of individual tested: _____
Mutations: _____ Laboratory at which testing was performed: _____

Ethnic Background

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

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