Please complete, print and submit. Reset Form

MAYO CLINIC
Mayo Medical Laboratories

SDHB, SDHC, SDHD Gene Testing Patient Information

Instructions: The accurate interpretation and reporting of the genetic results is contingent upon the reason for referral, clinical information, ethnic background, and family history. To help provide the best possible service, please supply the information requested below and **send paperwork with the specimen.**

Patient Information

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

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

Purpose of Study *(check all that apply)*

Clinical Status: ☐ Symptomatic ☐ Asymptomatic
Study Purpose: ☐ Diagnostic ☐ Presymptomatic

NOTE: If testing for a previously identified familial SDHB, SDHC, or SDHD mutation or variant is desired, order test FMTT / Familial Mutation, Targeted Testing and provide documentation of the familial mutation or variant to the laboratory by attaching a copy of the genetic test lab report and filling in the familial mutation or variant below.

- Mutation or variant to be detected: _____
- Proband's relationship to the patient: _____

Pertinent Clinical and Laboratory History *(check all that apply)*

Paragangliomas? ☐ Yes ☐ No If yes, number and location: _____

Pheochromocytomas? ☐ Yes ☐ No If yes, unilateral or bilateral? ☐ Unilateral ☐ Bilateral

Renal Cell Carcinoma? ☐ Yes ☐ No Other tumors? ☐ Yes ☐ No If yes, specify: _____

Hypertension? ☐ Yes ☐ No Headaches? ☐ Yes ☐ No Profuse sweating? ☐ Yes ☐ No

Palpitations? ☐ Yes ☐ No Anxiety? ☐ Yes ☐ No

List supporting biochemical test results:

Other relevant clinical information (surgeries, malignancy, etc.):

Ethnic Background - *Ethnic background is necessary to provide appropriate interpretation of test results.*

☐ European Caucasian ☐ African American ☐ Hispanic

☐ Asian ☐ Other (specify) _____

Indicate countries of origin:

Family History (Include a detailed pedigree, if available)

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

Have other relatives had molecular genetic testing for SDHB, SDHC, or SDHD? ☐ Yes ☐ No If yes, which gene: _____

If yes, indicate the performing laboratory and attach a copy of the genetic test lab report if available: _____

If the relative was tested at Mayo Clinic, include the name of the family member: _____

Print