Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Bruton Tyrosine Kinase (BTK) Genotype Patient Information

B T K G P T I N

Instructions: Accurate interpretation and reporting of the genetic results is contingent upon the reason for referral, clinical information, ethnic background, and family history information provided. Supply the information requested below and **send a completed copy of this form with the specimen**.

Patient Information (required)

Patient Name *(Last, First, Middle)*	Birth Date *(mm-dd-yyyy)*	Sex ☐ Male ☐ Female
Referring Provider Name *(Last, First)*	Phone	Fax*
Other Contact Name *(Last, First)*	Phone	Fax*

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

Reason for Testing and Clinical History (check all that apply)

Treatment History			Date Started *(mm-dd-yyyy)*
Previous diagnosis of X-linked Agammaglobulinemia (XLA)?	☐ Yes	☐ No	
Immunoglobulin treatment?	☐ Yes	☐ No	Date Last Received *(mm-dd-yyyy)*

Pertinent Clinical and Laboratory History					
Hypogammaglobulinemia (low IgG, IgM, IgA)	☐ Yes	☐ No	Sinusitis	☐ Yes	☐ No
Common Variable Immunodeficiency (CVID)	☐ Yes	☐ No	Tonsils present	☐ Yes	☐ No
Recurrent infections	☐ Yes	☐ No	Lymph nodes present	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No	Splenomegaly	☐ Yes	☐ No
CD19+ B-cells present in blood (>1%)	☐ Yes	☐ No			
Btk protein by flow cytometry	☐ Present	☐ Absent	☐ Equivocal	☐ Carrier	☐ Unknown

Other Diagnosis

Other Information (such as allogeneic stem cell transplant; indicate type [myeloablative vs. non-myeloablative] and date)

Ethnic Background (Ethnic background may assist with interpretation of test results.)

☐ European/Caucasian, list countries of origin: _____

☐ African American ☐ Hispanic ☐ Asian ☐ Other, specify: _____

Family History

Normal	☐ Father	☐ Mother	☐ Siblings
Hypogammaglobulinemia (low IgG and/or IgM, IgA)	☐ Father	☐ Mother	☐ Siblings
CVID	☐ Father	☐ Mother	☐ Siblings
Recurrent infections	☐ Father	☐ Mother	☐ Siblings
Are other male relatives known to be affected?	☐ Yes	☐ No	If yes, indicate their relationship to the patient:
Are other female relatives known to be a carrier?	☐ Yes	☐ No	If yes, indicate their relationship to the patient:
Have other relatives had molecular genetics testing?	☐ Yes	☐ No	If yes, indicate their relationship to the patient:

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

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