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MAYO CLINIC LABORATORIES

Calcium Sensing Receptor (CASR) Gene Testing 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.**

Patient Information

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

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

Reason for Testing

What is the suspected diagnosis?

- ☐ Familial hypocalciuric hypercalcemia (FHH)
- ☐ Neonatal severe primary hyperparathyroidism (NSPHPT)
- ☐ Autosomal dominant hypocalcemia (ADH)
- ☐ Bartter syndrome type V

Patient presentation of hypercalcemia or hypocalcemia?

☐ Yes ☐ No ☐ Unknown

If Yes, ☐ Hypercalcemia or ☐ Hypocalcemia:

Family history of hypercalcemia or hypocalcemia?

☐ Yes ☐ No ☐ Unknown

If Yes, indicate hyper or hypo and list affected family members:

Family member with known CASR mutation?

☐ Yes ☐ No ☐ Unknown

If Yes, indicate exon or nucleotide and list affected family members:

Print