Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

GATA2 Gene Sequencing Patient Information

Instructions: 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*

Ethnic origin/race/ethnic background may assist with interpretation of test results. Check all that apply.

☐ African ☐ African American ☐ Arab ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Jewish ☐ Native American

☐ Amish/Mennonite: list geographic region in the US: _____

☐ Other/additional details: _____

☐ Specify country and tribe, if known: _____

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

Clinical History Check all that apply.

Patient's clinical status ☐ Asymptomatic ☐ Symptomatic ☐ Other: _____

Indicate whether the following are present:

☐ Warts ☐ Mycobacterial disease ☐ Viral infections

☐ Cytopenias (neutropenia, monocytopenia, B cell/NK cell/CD4+ T cell lymphopenia) ☐ Pulmonary alveolar proteinosis (PAP)

☐ Myelodysplastic syndrome (MDS) ☐ Acute myeloid leukemia (AML) ☐ Emberger syndrome

☐ Other malignancies; specify: _____

☐ Lymphedema (eg, legs, genitals); specify: _____

Preliminary screening results:

☐ WBC _____; Absolute Neutrophil count _____; Monocyte count _____; Absolute Lumphocyte count _____

☐ Lymphocyte counts: CD19+ or CD20+ B cell _____; CD4+ T cell _____; CD16/56+ NK cell _____

☐ Dendritic cell (DC) phenotyping performed: If yes, where: _____ ☐ Normal ☐ Abnormal

Patient treatment history:

☐ No treatment ☐ Chemotherapy

☐ Allogeneic Hematopoietic cell transplant (blood, BM, cord); if transplanted, specify cell source:

☐ BM ☐ PB ☐ Cord blood; donor: ☐ MRD MURD ☐ Haplo ☐ Cord

☐ Conditioning received: conditioning date *(mm-dd-yyyy)*: _____

☐ T cell-depleted HCT

☐ Transplant date *(mm-dd-yyyy)*: _____

Treatment for infections; specify: _____

Other relevant clinical history: _____

Diagnosis date, if applicable *(mm-dd-yyyy)*: _____

Family History Attach 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? ☐ Yes ☐ No

Other Relevant Information

Print