Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Molecular Genetics: Biochemical Disorders 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 or return by fax to Mayo Clinic Laboratories, Attn: Molecular Genetics Lab Genetic Counselors at 507-284-1759**.

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

☐ **Carrier Screen** (Check the appropriate box.)

- ☐ Clinically normal individual with no family history of the condition
- ☐ Family history of the condition; if checked, complete Family History section
- ☐ Spouse has family history of the condition
- ☐ Spouse is a carrier of the condition
- ☐ Biochemical testing indicates the individual is a carrier
- ☐ Anonymous egg or sperm donor

☐ **Diagnosis or Suspected Diagnosis**

List all relevant clinical symptoms and results of any applicable biochemical diagnostic tests (ie, plasma acylcarnitines, urine acylglycines, urine organic acids, enzyme testing, ceruloplasmin, copper quantitation serum/urine):

Ethnic Background

Ethnic background is necessary to provide appropriate interpretation of test results. Check the appropriate box.

☐ African American ☐ Asian ☐ Hispanic ☐ Northern European Caucasian
☐ Ashkenazi Jewish ☐ French Canadian ☐ Mixed European Caucasian ☐ Southern European Caucasian
☐ Caucasian; indicate countries of origin: _____ ☐ Other, specify: _____

Pregnancy Information

Is the patient or partner currently pregnant? ☐ Yes ☐ No

Family History

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

Are other relatives known to be carriers? ☐ Yes ☐ No If Yes, relationship to patient: _____

Have other relatives had molecular genetic testing? ☐ Yes ☐ No If Yes, complete the information below for the individual tested:

Gene: _____ Name *(First, Middle, Last)*: _____

Birth Date *(mm-dd-yyyy)*: _____ Mutations: _____

Laboratory where testing was performed: _____

Print