

Molecular Genetics: Congenital Inherited Diseases 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 o	iven must be from a fax machine that co	omplies with applicable HIPAA regulation			

Referring Provider Name (Last, First)		Phone		Fax*	
Genetic Counselor Name (Last, First)		Phone		Fax*	
Reason for Testing	* <i>F</i>	ax number given must b	e from a fax machine that con	 mplies with applicable HIPAA regulations	
 □ Carrier Screen (Check the appropriate box.) □ Clinically normal individual with no family hi □ Family history of the condition; if checked, o □ Spouse has family history of the condition 	•		☐ Spouse is a carrier of ☐ Anonymous egg or		
☐ Diagnosis or Suspected Diagnosis List all relevant clinical symptoms:					
Ethnic Background Ethnic background is no This is especially important for cystic fibrosis testing		e appropriate interp	oretation of test results.	Check the appropriate boxes.	
☐ African American ☐ Asian	☐ Hispanic		☐ Northern European	Caucasian	
☐ Ashkenazi Jewish ☐ French Canadian	☐ Mixed Europe	ean Caucasian	☐ Southern European	Caucasian	
☐ Caucasian; indicate countries of origin:	☐ Other, specify:				
Pregnancy Information					
Is the patient or partner currently pregnant?	□ Yes □ No	If Yes, how many	weeks gestation?		
Family History					
Are other relatives known to be affected?	□ Yes □ No	If Yes, indicate rel	Yes, indicate relationship to patient:		
Are other relatives known to be carriers?	□ Yes □ No	If Yes, indicate rel	es, indicate relationship to patient:		
Have other relatives had molecular genetic testing? Gene:		•	If Yes, complete the information below:		
Name of individual tested (Last, First, Middle):					
Birth date of individual tested (mm-dd-yyyy):					
Mutations:					
Laboratory at which testing was performed:					