Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Whole Exome Sequencing Test Request

WES / Whole Exome Sequencing, Varies

Client Information (required)

Client Name		
Client Account No.		
Client Phone	Client Order No.	
Address		
City	State	Zip Code

Patient Information (required)

Patient ID (Medical Record No.)		
Patient Name *(Last, First, Middle)*		
Sex ☐ Male ☐ Female	Birth Date *(mm-dd-yyyy)*	
Collection Date *(mm-dd-yyyy)*	Time	☐ am ☐ pm

Reason for Testing (required)

ICD-10 Diagnosis Code

Note: It is the client's responsibility to maintain documentation of the order.

New York State Patients: Informed Consent for Genetic Testing

MCL Internal Use Only

Submitting Provider/Provider Name Information (required)

Submitting/Referring Provider *(Last, First)*
Phone ( ) _____ – _____ Fax* ( ) _____ – _____
Provider's National ID (NPI)
Other Contact/Geneticist/Genetic Counselor *(Last, First)*
Phone ( ) _____ – _____ Fax* ( ) _____ – _____

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

Ship specimens to:

Mayo Clinic Laboratories
3050 Superior Drive NW
Rochester, MN 55901

Customer Service: 800-533-1710

Visit www.MayoClinicLabs.com for the most up-to-date test and shipping information.

Billing Information

- An itemized invoice will be sent each month.
- Payment terms are net 30 days.

Call the Business Office with billing related questions:
800-447-6424 (US and Canada)
507-266-5490 (outside the US)

Print