MAYO CLINIC
Mayo Medical Laboratories

Molecular Genetics – Congenital Inherited Diseases Patient Information Sheet

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, please supply the information requested below and **send paperwork with the specimen or return by fax to Laboratory Genetics 507-284-0670 (phone 507-538-2996).**

Name of Patient	Gender ☐ Male ☐ Female	Date of Birth mm/dd/yyyy

Check box(es) below and complete information to indicate who should receive reports.

☐ Requesting Physician	Phone Number	Fax Number
☐ Genetic Counselor	Phone Number	Fax Number
MML Account Number		

Reason for Testing

☐ **CARRIER SCREEN**

- ☐ Clinically normal individual with no family history of the condition
- ☐ Family history of the condition
- ☐ Spouse has family history of the condition
- ☐ Spouse is a carrier of the condition
- ☐ Anonymous egg or sperm donor

☐ **DIAGNOSIS OR SUSPECTED DIAGNOSIS**
List all relevant clinical symptoms:

* If testing for **Cystic Fibrosis**, and reason for referral is male infertility, provide specific diagnostic information such as: azoospermia, obstructive azoospermia, congenital bilateral absence of the vas deferens (CBAVD), unilateral absence of the vas deferens, oligospermia etc.:

Ethnic Background – *Ethnic background is necessary to provide appropriate interpretation of test results. Please check appropriate box. Especially important for Cystic Fibrosis testing.*

☐ Northern European Caucasian ☐ Hispanic ☐ Ashkenazi Jewish ☐ Southern European Caucasian
☐ Mixed European Caucasian ☐ Asian ☐ French Canadian ☐ African American
☐ Caucasian – Please 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 their relationship to the patient:
Are other relatives known to be a carrier? ☐ Yes ☐ No	If yes, indicate their relationship to the patient:
Have other relatives had molecular genetic testing? ☐ Yes ☐ No	If yes, indicate the results (specific mutation(s) identified and the laboratory at which testing was performed):
If the relative was tested at the Mayo Clinic, include the name of the family member:	