

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.**

Phone: 800-533-1710 / International clients: 855-379-3115 or +1-507-284-9273, or email mliintl@mayo.edu

Patient Information

Patient Name (Last, First Middle)		Birth Date (mm-dd-yyyy)
Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Choose not to disclose		Legal/Administrative Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary

Referring Healthcare Professional Information

Referring Healthcare Professional 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

Study purpose: Diagnostic Presymptomatic/Family history

Working Clinical Diagnosis (describe)

Ethnic Background

African/African American
 East Asian
 Latinx/Latine
 South Asian
 Unknown
 Ashkenazi Jewish
 European
 Middle Eastern
 None of the above
 Choose not to disclose
 Other, specify: _____
 Indicate countries of origin: _____

Family History

If testing is being performed for an asymptomatic individual due to a family history, note that pretest genetic counseling is strongly recommended.

Are other relatives known to be affected? No Yes If Yes, indicate their relationship to the patient and list their symptoms:

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

Genes: _____

Mutations: _____

Name of individual tested (Last, First Middle): _____

Birth date of individual tested (mm-dd-yyyy): _____

Laboratory at which testing was performed: _____

Patient Information

Patient Name (Last, First Middle)	Birth Date (mm-dd-yyyy)
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Clinical Information Check all that apply or fax most recent clinic note.

Autonomic	<input type="checkbox"/> Abnormal sweating	<input type="checkbox"/> Dysphagia	<input type="checkbox"/> Shortness of breath
	<input type="checkbox"/> Abnormal temperature regulation	<input type="checkbox"/> Orthostatic dizziness/fainting	
Cardiac	<input type="checkbox"/> Abnormal heart rate	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Cardiomyopathy
		<input type="checkbox"/> Palpitations	
Cognitive	<input type="checkbox"/> Behavioral changes	<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Intellectual disability
	<input type="checkbox"/> Cognitive decline	<input type="checkbox"/> Developmental delay	<input type="checkbox"/> Memory loss
Craniofacial	<input type="checkbox"/> Blindness	<input type="checkbox"/> Eye movement disorder	<input type="checkbox"/> Ptos
	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Retinitis pigmentosa
	<input type="checkbox"/> Dysmorphic features	<input type="checkbox"/> Optic atrophy	<input type="checkbox"/> Tinnitus
Endocrine	<input type="checkbox"/> Abnormal parathyroid function, check one:	<input type="checkbox"/> Hypo	<input type="checkbox"/> Hyper
	<input type="checkbox"/> Abnormal thyroid function, check one:	<input type="checkbox"/> Hypo	<input type="checkbox"/> Hyper
	<input type="checkbox"/> Diabetes mellitus		
GI	<input type="checkbox"/> Chronic diarrhea	<input type="checkbox"/> Cyclic vomiting	<input type="checkbox"/> Incontinence
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Gastroparesis	<input type="checkbox"/> Loss of appetite
Muscular	<input type="checkbox"/> Easy fatigue	<input type="checkbox"/> Hypotonia	<input type="checkbox"/> Muscle wasting
	<input type="checkbox"/> Hypertonia	<input type="checkbox"/> Muscle stiffness	<input type="checkbox"/> Muscle weakness
		<input type="checkbox"/> Myalgia	<input type="checkbox"/> Myotonia
Neurological	<input type="checkbox"/> Abnormal balance	<input type="checkbox"/> Cerebellar atrophy	<input type="checkbox"/> Foot drop
	<input type="checkbox"/> Ataxia	<input type="checkbox"/> Chorea	<input type="checkbox"/> Gait abnormality
	<input type="checkbox"/> Bradykinesia	<input type="checkbox"/> Dysarthria	<input type="checkbox"/> Hallucinations
	<input type="checkbox"/> Brain malformation	<input type="checkbox"/> Dystonia	<input type="checkbox"/> Pain
	<input type="checkbox"/> Deep tendon, check one:	<input type="checkbox"/> Absent	<input type="checkbox"/> Increased
		<input type="checkbox"/> Decreased	<input type="checkbox"/> Vertigo
	<input type="checkbox"/> Neuropathy, check one:	<input type="checkbox"/> Motor	<input type="checkbox"/> Sensory
		<input type="checkbox"/> Sensorimotor	<input type="checkbox"/> Autonomic
	<input type="checkbox"/> Weakness, check one:	<input type="checkbox"/> Distal	<input type="checkbox"/> Proximal
Psychiatric	<input type="checkbox"/> Mood changes	<input type="checkbox"/> Psychiatric disturbance/diagnosis	<input type="checkbox"/> Sleep disturbances
Seizures/Epilepsy	<input type="checkbox"/> Absence seizures	<input type="checkbox"/> Febrile seizures	<input type="checkbox"/> Generalized seizures
	<input type="checkbox"/> Epileptic encephalopathy	<input type="checkbox"/> Focal seizures	<input type="checkbox"/> Infantile/Epileptic spasms
Skeletal/Limb Abnormalities	<input type="checkbox"/> Club foot	<input type="checkbox"/> Hammer toe	<input type="checkbox"/> Pes cavus
	<input type="checkbox"/> Contractures	<input type="checkbox"/> Painless foot ulcers	<input type="checkbox"/> Pes planus
Other Manifestations	<input type="checkbox"/> Other, specify: _____		

At what age did symptoms present?

Has previous testing been performed for this patient? No Yes If Yes, complete information below.

- Sequencing for genes: _____
- Deletion/Duplication for genes: _____
- Electromyography/nerve conduction study (EMG/NCS); describe: _____
- Ulnar motor forearm nerve conduction velocity (m/s) and distal amplitude (mV) and/or R1 blink latency (ms): _____
- Imaging [eg, brain magnetic resonance imaging (MRI)]: _____
- Muscle biopsy; describe: _____
- Creatine kinase (CK) level; describe: _____