

**Instructions:** This form is intended to be completed by the ordering healthcare professional. Accurate interpretation and reporting of genetic results is contingent upon the reason for testing/clinical information, familial variants, 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.** For more information regarding this form, contact the Genetic Counselors at **800-533-1710 / International clients: 855-379-3115 or +1-507-284-9273, or email [mliintl@mayo.edu](mailto:mliintl@mayo.edu)**

## Patient Information

Patient Name (Last, First Middle)		Birth Date (mm-dd-yyyy)	
Preferred Name		Medical Record Number (if Birth Date is not available)	
Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other, specify: _____		Legal/Administrative Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other, specify: _____	
Gender Identity (optional)		Pronouns (optional)	

## 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/Clinical Information

Patient's Clinical Status:    Symptomatic    Asymptomatic   If "Symptomatic," provide symptoms/clinical history in the space below:

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## Mutation/Variant Information

This testing cannot be performed without the information below.\*\*

Is the familial variant a nucleotide substitution or small insertion/deletion of nucleotides?    Yes    No   If "Yes," provide the familial variant(s) here:

Variant	Gene	Transcript	Exon/Intron	Amino Acid	cDNA	gDNA
1:						
2:						
3:						

Is the familial variant a large deletion or duplication involving one or more exons?    Yes    No  
 If "Yes," provide the familial deletion/duplication here:    Deletion    Duplication  
 Gene: \_\_\_\_\_   Exons: \_\_\_\_\_   Genomic breakpoints, if known: \_\_\_\_\_

\*\*Analysis of regions surrounding the familial variant may be required and may result in the identification of additional sequence variants.

## Biological Family History

Include the name(s) and birth date(s) of the biological family member(s) who have had genetic testing (ie, proband):

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Indicate the biological family member's relationship to the patient: \_\_\_\_\_

**Important: Attach a copy of the proband's genetic test result and a detailed biological family history, if available.**