



Instructions: This form is intended to be completed by the ordering healthcare professional. Accurate interpretation and reporting of the genetic results is contingent upon the reason for referral, clinical information, family history, and ancestry. To help provide the best possible service, supply the information requested below and **send paperwork with the specimen, or return by fax to Mayo Clinic Laboratories, Attn: Molecular Technologies Laboratory 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)
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)	
Ancestry: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Choose not to disclose		

Referring Healthcare Professional Information

Referring Healthcare Professional Name (Last, First)	Phone	Fax*
Other Contact Name (Last, First)	Phone	Fax*

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

Reason for Testing Select one or more of the following indications for testing.

<input type="checkbox"/> Diagnosis/Suspected diagnosis <input type="checkbox"/> Gilbert syndrome <input type="checkbox"/> Crigler-Najjar syndrome: <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Carrier testing	<input type="checkbox"/> Pharmacogenomic screening <input type="checkbox"/> Irinotecan <input type="checkbox"/> Belinostat <input type="checkbox"/> Atazanavir <input type="checkbox"/> Nilotinib <input type="checkbox"/> Pazopanib <input type="checkbox"/> Other, specify: _____
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Clinical History

Laboratory Data Date last bilirubin was performed (mm-dd-yyyy): _____ Total bilirubin: _____ mg/dL Conjugated (direct) bilirubin: _____ mg/dL Older significant bilirubin levels: _____ Symptoms: <input type="checkbox"/> Hyperbilirubinemia <input type="checkbox"/> Other, specify: _____	History of suspected UGT1A1-associated drug toxicity or adverse drug reaction? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide: <input type="checkbox"/> Irinotecan <input type="checkbox"/> Belinostat <input type="checkbox"/> Atazanavir <input type="checkbox"/> Nilotinib <input type="checkbox"/> Pazopanib <input type="checkbox"/> Other, specify: _____ Reaction/Symptoms: <input type="checkbox"/> Neutropenia <input type="checkbox"/> Diarrhea <input type="checkbox"/> Other, specify: _____
Additional Comments _____ _____	

Biological Family History

Other biological relatives known to be affected? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," indicate their relationship to the patient: _____ Have other biological relatives had UGT1A1 molecular genetic testing? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," indicate: Performing laboratory for biological relative's testing: _____ UGT1A1 variants detected in biological relative: _____ If relative was tested at Mayo Clinic, name and relationship of biological relative: _____ Attach a copy of the genetic test lab report, if available.
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