



**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 testing, indications, clinical history, 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](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**

Requesting 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** Check all that apply.

<input type="checkbox"/> Diagnosis <input type="checkbox"/> Presymptomatic diagnosis** <input type="checkbox"/> Prenatal <input type="checkbox"/> Biological Family History** <input type="checkbox"/> Transplant Evaluation <input type="checkbox"/> Other; specify: _____
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\*\*Genetic testing should be performed on an affected family member first, when possible. FMTT / Familial Variant, Targeted Testing should be ordered when there is a previous positive genetic test result in the family.

**Indications** Check all that apply.

<input type="checkbox"/> <b>Alagille syndrome</b> <input type="checkbox"/> Congenital heart defect <input type="checkbox"/> Butterfly vertebrae <input type="checkbox"/> Cholestasis <input type="checkbox"/> Liver disease <input type="checkbox"/> Elevated liver enzymes <input type="checkbox"/> <b>Alport syndrome</b> <input type="checkbox"/> Hematuria and/or proteinuria <input type="checkbox"/> Hearing loss <input type="checkbox"/> Glomerular basement membrane thinning <input type="checkbox"/> Reduced or absent collagen IV staining <input type="checkbox"/> <b>Complement defects</b> <input type="checkbox"/> Thrombotic microangiopathy (TMA)/Atypical hemolytic uremic syndrome (aHUS) <input type="checkbox"/> Thrombotic thrombocytopenic purpura (TTP) <input type="checkbox"/> Complement 3 glomerulopathy (C3G)	<input type="checkbox"/> <b>Congenital anomalies of the kidney and urinary tract (CAKUT)</b> <input type="checkbox"/> Renal agenesis/hypodysplasia <input type="checkbox"/> Structural kidney/ureter differences; specify: _____ <input type="checkbox"/> Other; specify: _____ <input type="checkbox"/> <b>Cystic kidney disease</b> <input type="checkbox"/> Autosomal dominant polycystic kidney disease (ADPKD) <input type="checkbox"/> Polycystic kidney disease <input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral <input type="checkbox"/> Cysts per kidney: R _____ L _____ <input type="checkbox"/> Liver cysts; number: _____ <input type="checkbox"/> Pancreas cysts; number: _____ <input type="checkbox"/> Nephronophthisis <input type="checkbox"/> <b>FGS/SRNS</b> <input type="checkbox"/> Biopsy proven focal segmental glomerulosclerosis <input type="checkbox"/> Steroid resistant nephrotic syndrome <input type="checkbox"/> Fabry disease <input type="checkbox"/> Other; specify: _____
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# Hereditary Renal Genetic Testing

## Patient Information (continued)

Patient Name (Last, First Middle)	Birth Date (mm-dd-yyyy)
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### Indications Check all that apply. (continued)

<input type="checkbox"/> <b>Nephrolithiasis/Nephrocalcinosis</b> <input type="checkbox"/> Kidney stones • Type: _____ • Recurrent: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Nephrocalcinosis  <input type="checkbox"/> <b>Bartter syndrome</b> <input type="checkbox"/> Hypokalemic hypochloremic alkalosis <input type="checkbox"/> Concentrating defect  <input type="checkbox"/> <b>Prenatal findings</b> <input type="checkbox"/> Polyhydramnios <input type="checkbox"/> Hydronephrosis <input type="checkbox"/> Oligohydramnios <input type="checkbox"/> Echogenic kidney(s) <input type="checkbox"/> Other; specify: _____	<input type="checkbox"/> <b>Renal electrolyte and related disorders</b> <input type="checkbox"/> Gitelman syndrome <input type="checkbox"/> Hypercalcemia <input type="checkbox"/> Hypercalciuria <input type="checkbox"/> Hypocalcemia <input type="checkbox"/> Hypocalciuria <input type="checkbox"/> Hypomagnesemia <input type="checkbox"/> Hypophosphatasia/Hypophosphatemic rickets <input type="checkbox"/> Hyperaldosteronism <input type="checkbox"/> Liddle syndrome/Severe idiopathic hypertension <input type="checkbox"/> Pseudohypoaldosteronism <input type="checkbox"/> Renal tubular acidosis (proximal/distal) <input type="checkbox"/> Other; specify: _____
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### Clinical History

<p><b>General Renal History</b></p> <input type="checkbox"/> Hematuria <input type="checkbox"/> Proteinuria <input type="checkbox"/> Aminoaciduria <input type="checkbox"/> Glucosuria <input type="checkbox"/> Polyuria <input type="checkbox"/> Oliguria <input type="checkbox"/> Renal salt wasting <input type="checkbox"/> Systemic lupus <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Acute kidney failure/injury <input type="checkbox"/> Exposure to nephrotoxic medications <input type="checkbox"/> Infectious disease; specify: _____  <p><b>Extra-Renal Findings</b></p> <input type="checkbox"/> Intracranial aneurysm <input type="checkbox"/> Retinitis pigmentosa or vision loss <input type="checkbox"/> Heterotaxy <input type="checkbox"/> Findings on brain MRI; specify: _____ <input type="checkbox"/> Characteristic facial features; specify: _____  <input type="checkbox"/> Structural ear differences; specify: _____ <input type="checkbox"/> Other; specify: _____  <p><b>Other Clinical History</b></p> <input type="checkbox"/> History of kidney transplant <input type="checkbox"/> History of immunosuppressive therapy <input type="checkbox"/> History of allogeneic hematopoietic stem cell transplantation <input type="checkbox"/> Other; describe: _____  <p><b>Current Medications:</b></p> <hr/> <hr/> <hr/> <hr/>	<p><b>Laboratory Findings</b></p> <p>Kidney Biomarkers</p> <input type="checkbox"/> eGFR/GFR: _____ <input type="checkbox"/> Creatinine clearance: _____ <input type="checkbox"/> TmP/GFR: _____ <input type="checkbox"/> Other; specify: _____  <p>Urine; describe or attach results from any relevant urine labs:</p> <hr/> <hr/> <hr/> <p>Pathology</p> <input type="checkbox"/> Kidney biopsy; describe or attach pathology results: <hr/> <hr/> <hr/> <p>Complement Serology</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> AH50:</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> C3:</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> C4:</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> C5:</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> CH50:</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> Factor B:</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> Factor D:</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> Factor H:</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> Factor I:</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> FH antibodies:</td> <td><input type="checkbox"/> Absent</td> <td><input type="checkbox"/> Present</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other; specify: _____</td> </tr> </table> <p>Soluble Biomarkers</p> <input type="checkbox"/> Shiga toxin: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> ADAMTS13: Activity _____%, Level _____  <p>Blood; describe or attach results from any relevant blood labs:</p> <hr/> <hr/> <hr/> <hr/>	<input type="checkbox"/> AH50:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> C3:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> C4:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> C5:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> CH50:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Factor B:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Factor D:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Factor H:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Factor I:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> FH antibodies:	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Other; specify: _____		
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# Hereditary Renal Genetic Testing

## Patient Information (continued)

Patient Name (Last, First Middle)	Birth Date (mm-dd-yyyy)
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### Patient Treatment History

Has the patient received an allogenic stem cell transplant***? <input type="checkbox"/> No <input type="checkbox"/> Yes; transplant date (mm-dd-yyyy): _____
Is the patient transfusion dependent***? <input type="checkbox"/> No <input type="checkbox"/> Yes; last transfusion date (mm-dd-yyyy): _____
Was this transfusion leukoreduced***? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown

\*\*\*Results may be inaccurate due to the presence of donor DNA if the patient has received an allogeneic hematopoietic stem cell transplant or non-leukocyte reduced blood products. Call Mayo Clinic Laboratories for instructions for testing patient who have received a bone marrow transplant.

### Biological Family History

Are there similarly affected biological relatives? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," indicate relationship and symptoms: _____ _____ _____
Have any biological family members had genetic testing? <input type="checkbox"/> Yes**** <input type="checkbox"/> No <input type="checkbox"/> Unknown

\*\*\*\*FMTT / Familial Variant, Targeted Testing should be ordered when there is a previous positive genetic test result in the family. Contact the lab for ordering assistance.

History of consanguinity <input type="checkbox"/> Yes If "Yes," relationship details: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Choose not to disclose
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### Patient Ancestry

Ancestry: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Choose not to disclose
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**New York State Patients: Informed Consent for Genetic Testing is required.** See Informed Consent for Genetic Testing (T576), Informed Consent for Genetic Testing – Spanish (T826).