Chromosomal Microarray Patient Information

MAYO CLINIC LABORATORIES

Instructions: The accurate interpretation and reporting of genetic results is contingent upon the reason for testing, clinical information, 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 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 (required)

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

Sex Assigned at Birth	Legal/Administrative Sex
☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose	☐ Male ☐ Female ☐ Nonbinary

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

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Clinical Information Check all that apply.

Perinatal History
- ☐ Prematurity
- ☐ Intrauterine growth restriction (IUGR)
- ☐ Oligohydramnios
- ☐ Polyhydramnios
- ☐ Abnormal prenatal testing (include copy of report): ____________
- ☐ Other: ____________

Growth
- ☐ Failure to thrive
- ☐ Overgrowth
- ☐ Short stature
- ☐ Other: ____________

Cognitive/Developmental
- ☐ Developmental delay
  - ☐ Fine motor delay
  - ☐ Gross motor delay
  - ☐ Speech delay
- ☐ Intellectual disability/MR
- ☐ Learning disability
- ☐ Other: ____________

Behavioral/Psychiatric
- ☐ ADHD
- ☐ Autism
- ☐ Oppositional-defiant disorder
- ☐ Obsessive-compulsive disorder
- ☐ Pervasive developmental delay
- ☐ Other: ____________

Cutaneous
- ☐ Hyperpigmentation
- ☐ Hypopigmentation
- ☐ Other: ____________

Neurological
- ☐ Ataxia
- ☐ Cerebral Palsy
- ☐ Encephalopathy
- ☐ Hypotonia
- ☐ Hypertonia
- ☐ Seizures
- ☐ Spasticity
- ☐ Structural brain anomaly
- ☐ Other: ____________

Cardiac
- ☐ Atrial septal defect
- ☐ Atrioventricular (AV) canal defect
- ☐ Tetralogy of Fallot
- ☐ Ventricular septal defect
- ☐ Other cardiac abnormality: ____________

Craniofacial
- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Craniosynostosis
- ☐ Dysmorphic features
- ☐ Ear malformation
- ☐ Macrocephaly
- ☐ Microcephaly
- ☐ Other: ____________

Hearing/Vision
- ☐ Abnormality o eye movement
- ☐ Abnormality of vision
- ☐ Hearing loss
- ☐ Other: ____________

Musuloskeletal
- ☐ Club foot
- ☐ Contractures
- ☐ Diaphragmatic hernia
- ☐ Limb anomaly
- ☐ Polydactyly
- ☐ Syndactyly
- ☐ Vertebral anomaly
- ☐ Other: ____________

Gastrointestinal
- ☐ Anal atresia
- ☐ Gastroschisis
- ☐ Omphalocele
- ☐ Pyloric stenosis
- ☐ Tracheoesophageal fistula
- ☐ Other: ____________

Genitourinary
- ☐ Ambiguous genitalia
- ☐ Cryptorchidism
- ☐ Hydronephrosis
- ☐ Hypospadias
- ☐ Kidney malformation
- ☐ Other: ____________

Family History
- ☐ Parents with 2 or more miscarriages
- ☐ Other relatives with similar clinical history; explain: ____________

Clinical Descriptions Include any additional relevant clinical information. List all previous genetic testing and provide report.

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