



Instructions: Accurate interpretation and reporting of genetic results is contingent upon the reason for testing, 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)
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 Specify below or attach relevant clinic note.

Confirm clinical diagnosis, specify diagnosis: _____ Age of onset: _____

Family history**, describe: _____

Other, specify: _____

**Genetic testing should be performed on an affected family member first, when available. FMTT / Familial Variant, Targeted Testing should be ordered when there is a previous positive genetic test result in the family.

Clinical Findings

Crohn's Disease Inflammatory Bowel Disease – Unclassified Ulcerative Colitis Age of onset: _____

Other, specify: _____

<input type="checkbox"/> Malabsorption <input type="checkbox"/> Celiac disease <input type="checkbox"/> Sclerosing cholangitis <input type="checkbox"/> Other gastrointestinal symptoms/disorders, describe: _____ <input type="checkbox"/> Arthritis/Arthralgias <input type="checkbox"/> Autoimmune disorder(s), describe: _____ <input type="checkbox"/> Enteropathy, describe: _____	<input type="checkbox"/> Endocrine abnormalities, describe: _____ <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Fever (recurrent) <input type="checkbox"/> Hepatosplenomegaly <input type="checkbox"/> Skin, hair, dental, or nail findings, describe: _____ <input type="checkbox"/> Uveitis <input type="checkbox"/> Veno-occlusive disease
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Infectious Disease History

Recurrent or difficult to treat infections: Viral Bacterial Fungal

Recurrent deep abscesses of the organs or skin

Gastrointestinal infections

Other infection, specify: _____

On immunoglobulin replacement

Early Onset Inflammatory Bowel Disease

Patient Information (continued)

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

- Fecal Calprotectin: Normal Increased
- IgA class antigliadin antibodies: Present Absent
- IgA class antitransglutaminase antibodies (tTGA): Present Absent
- IgA class endomysial antibodies: Present Absent
- Abnormal lymphocyte (T-, B-, and NK-cell) subset quantitation; describe or attach report: _____

Humoral markers:

- Abnormal B-cell function (vaccine antibody responses)
- Autoantibodies present, specify: _____
- Immunoglobulins:
- IgG: Increased Decreased
 - IgG1: Increased Decreased IgG3: Increased Decreased
 - IgG2: Increased Decreased IgG4: Increased Decreased
 - IgA: Increased Decreased
 - IgM: Increased Decreased
 - IgD: Increased Decreased
 - IgE: Increased Decreased

Cellular markers:

- Abnormal TREC assay (eg, newborn screening)
- Abnormal T-cell function: Mitogens Antigens Anti-CD3 Anti-CD3/CD28 Cytokine production
- T-cell subsets:
- Naive: Increased Decreased Activated: Increased Decreased
 - Memory: Increased Decreased
- B-cell subsets:
- Naive: Increased Decreased Marginal zone B-cells: Increased Decreased
 - Memory: Increased Decreased Transitional B-cells: Increased Decreased
 - Switched memory: Increased Decreased Plasmablasts: Increased Decreased
- Oligoclonal T-cells or abnormal TCRVB spectratyping
- Abnormal CD4 T-cell recent thymic emigrants, flow cytometry
- Abnormal haemophilus influenzae B vaccine response
- Abnormal HLA typing for class I or class II HLA antigens
- Abnormal streptococcus pneumoniae IgG antibody response

Specific protein assay by flow cytometry:

- BTK: Normal Abnormal WAS: Normal Abnormal
- LRBA: Normal Abnormal XIAP: Normal Abnormal
- DOCK8: Normal Abnormal SAP: Normal Abnormal
- Other, specify: _____

Blood:

- Autoimmune cytopenia Eosinophilia Lymphocytosis Lymphopenia Thrombocytopenia
- Other hematological abnormality, specify: _____
- Other laboratory findings, specify: _____
- If the patient has had GI biopsies, attach a copy of the pathology report.

Early Onset Inflammatory Bowel Disease

Patient Information (continued)

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

<input type="checkbox"/> Myelodysplasia/AML	<input type="checkbox"/> Leukemia, specify: _____
<input type="checkbox"/> Lymphoma, specify: _____	<input type="checkbox"/> Skin cancer, specify: _____
<input type="checkbox"/> Solid tumor, specify: _____	<input type="checkbox"/> Other, specify: _____
<input type="checkbox"/> Family history of cancer; specify cancer type and biological relationship to patient: _____	

Patient Treatment History

Has the patient received an allogeneic 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
Chemotherapy: <input type="checkbox"/> No <input type="checkbox"/> Yes; date (mm-dd-yyyy): _____
***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 patients who have received a bone marrow transplant.

Family History

Are there similarly affected relatives? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," indicate relationship, and diagnosis or symptoms: _____
Have any family member 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"/> No <input type="checkbox"/> Yes; relationship details: _____

Ancestry

<input type="checkbox"/> African/African American	<input type="checkbox"/> East Asian	<input type="checkbox"/> Latinx/Latine	<input type="checkbox"/> South Asian	<input type="checkbox"/> Unknown
<input type="checkbox"/> Ashkenazi Jewish	<input type="checkbox"/> European	<input type="checkbox"/> Middle Eastern	<input type="checkbox"/> None of the above	<input type="checkbox"/> Choose not to disclose

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), or Informed Consent for Genetic Testing for Deceased Individuals (T782).