Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

PKLR Gene Sequencing Patient Information

Instructions: The accurate interpretation and reporting of genetic results is contingent upon the reason for testing, ancestry, family history, and clinical 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 Hematopathology 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 ☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose	Legal/Administrative Sex ☐ Male ☐ Female ☐ Nonbinary	

Referring Healthcare Professional Information

Requesting Healthcare Professional Name (Last, First)	Phone	Fax*
Healthcare Professional Email		
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

Ancestry

☐ African/African American	☐ East Asian	☐ Latinx/Latine	☐ South Asian	☐ Unknown
☐ Ashkenazi Jewish	☐ European	☐ Middle Eastern	☐ None of the above	☐ Choose not to disclose
☐ Other, specify:		☐ Indicate countries of origin:		

Family History

Are other relatives known to be affected? ☐ Yes ☐ No If "Yes," describe symptoms and relationship to patient:

If a relative was tested at Mayo Clinic, family member name (Last, First Middle)

Clinical History

Reason for Testing

☐ PK enzyme level:	☐ Neonatal anemia	☐ Known previous diagnosis:
☐ Chronic anemia	☐ Hyperbilirubinemia/Jaundice	
☐ Carrier testing	☐ Iron overload:	Previously tested at Mayo Clinic: ☐ Yes ☐ No
☐ Pigmented gallstones	☐ Other:	

RBC	HGB	HCT	MCV	RDW	MCH	Ferritin
☐ Reticulocyte count		p50	Coombs test: ☐ Positive	☐ Negative	☐ Not done	Therapy

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Calcium Sensing Receptor (CASR)
Gene Testing Patient Information (continued)

Clinical History (continued)

Patient recently transfused: ☐ Yes ☐ No ☐ Unknown Last transfusion(s) date(s) (mm-dd-yyyy):
☐ Splenomegaly Splenectomy: ☐ Yes ☐ No Date (mm-dd-yyyy): _____ ☐ Phototherapy ☐ No therapy
Other Relevant Clinical Information
Peripheral blood smear shows:

Print

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