

Molecular Genetics-Congenital Inherited Diseases Patient Information Sheet (Supply T521)



*Molecular Genetics – Congenital Inherited Diseases
Patient Information Sheet*

The accurate interpretation and reporting of genetic results is contingent upon the reason for referral, clinical information, ethnic background, and family history. To help provide the best possible service, please supply the information requested below and **send paperwork with the specimen or return by fax to Laboratory Genetics 507-284-0670 (phone 507-538-2996).**

Patient Name <i>(Last, First, Middle)</i>	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date <i>(Month DD, YYYY)</i>
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Check box(es) below and complete information to indicate who should receive reports.

<input type="checkbox"/> Requesting Physician	Phone	Fax
<input type="checkbox"/> Genetic Counselor	Phone	Fax
MML Account Number		

Reason for Testing

<input type="checkbox"/> CARRIER SCREEN - Please check appropriate box <input type="checkbox"/> Clinically normal individual with no family history of the condition <input type="checkbox"/> Family history of the condition <input type="checkbox"/> Spouse has family history of the condition		<input type="checkbox"/> Spouse is a carrier of the condition <input type="checkbox"/> Anonymous egg or sperm donor	
<input type="checkbox"/> DIAGNOSIS OR SUSPECTED DIAGNOSIS List all relevant clinical symptoms:			

Ethnic Background – Ethnic background is necessary to provide appropriate interpretation of test results. Please check appropriate box. Especially important for Cystic Fibrosis testing.

<input type="checkbox"/> Northern European Caucasian	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Ashkenazi Jewish	<input type="checkbox"/> Southern European Caucasian
<input type="checkbox"/> Mixed European Caucasian	<input type="checkbox"/> Asian	<input type="checkbox"/> French Canadian	<input type="checkbox"/> African American
<input type="checkbox"/> Caucasian - Please indicate countries of origin _____		<input type="checkbox"/> Other (specify): _____	

Pregnancy Information

Is the patient or partner currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many weeks gestation? _____
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Family History

Are other relatives known to be affected? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate their relationship to the patient:
Are other relatives known to be a carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate their relationship to the patient:
Have other relatives had molecular genetic testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate the results (specific mutation(s) identified and the laboratory at which testing was performed):
If the relative was tested at the Mayo Clinic, include the name of the family member:	

