Complete, print and submit.

MAYO CLINIC LABORATORIES

Molecular Genetics: Neurology Patient Information

Reset Form

Instructions: 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, supply the information requested below and **send this paperwork with the specimen or return by fax to the Molecular Genetics Laboratory 507-284-0670**.

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date *(mm-dd-yyyy)*	Gender ☐ Male ☐ Female
Referring Provider Name *(Last, First)*	Phone	Fax*
Genetic Counselor	Phone	Fax*

**Fax number given must be from a fax machine that complies with applicable HIPAA regulations.*

Reason for Testing

Study purpose: ☐ Diagnostic ☐ Presymptomatic/Family history

Working Clinical Diagnosis (describe)

Clinical History Check all that apply or alternatively fax most recent clinic note.

Autonomic	☐ Abnormal sweating ☐ Orthostatic dizziness/fainting	☐ Abnormal temperature regulation ☐ Shortness of breath	☐ Dysphagia
Cardiac	☐ Abnormal heart rate ☐ Palpitations	☐ Arrhythmia	☐ Cardiomyopathy
Cognitive	☐ Behavioral changes ☐ Difficulty concentrating ☐ Speech/Language difficulties	☐ Cognitive decline ☐ Intellectual disability	☐ Developmental delay ☐ Memory loss
Craniofacial	☐ Blindness ☐ Eye movement disorder ☐ Ptosis ☐ Visual impairment	☐ Cataracts ☐ Hearing loss ☐ Retinitis pigmentosa	☐ Dysmorphic features ☐ Optic atrophy ☐ Tinnitus
Endocrine	☐ Abnormal parathyroid function, check one: ☐ Hypo ☐ Hyper ☐ Abnormal thyroid function, check one: ☐ Hypo ☐ Hyper ☐ Diabetes mellitus		
GI	☐ Chronic diarrhea ☐ Gastroparesis	☐ Constipation ☐ Incontinence	☐ Cyclic vomiting ☐ Loss of appetite
Muscular	☐ Easy fatigue ☐ Muscle stiffness ☐ Myalgia	☐ Hypertonia ☐ Muscle wasting ☐ Myotonia	☐ Hypotonia ☐ Muscle weakness
Neurological	☐ Abnormal balance ☐ Cerebellar atrophy ☐ Dysarthria ☐ Foot drop ☐ Recurrent headache ☐ Strokes ☐ Deep tendon, check one: ☐ Absent ☐ Increased ☐ Neuropathy, check one: ☐ Motor ☐ Sensory ☐ Weakness, check one:	☐ Ataxia ☐ Chorea ☐ Dystonia ☐ Gait abnormality ☐ Rigidit ☐ Tremor ☐ Decreased ☐ Sensorimotor ☐ Autonomic ☐ Distal ☐ Proximal	☐ Brain malformation ☐ Pain ☐ Paresthesia ☐ Hallucinations ☐ Paraplegia ☐ Poor coordination ☐ Spasticity ☐ Vertigo

Patient Information

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

Psychiatric

☐ Mood changes ☐ Psychiatric disturbance/diagnosis ☐ Sleep disturbances

Seizures/Epilepsy

☐ Absence seizures ☐ Epileptic encephalopathy ☐ Febrile seizures ☐ Focal seizures
☐ Generalized seizures ☐ Infantile/Epileptic spasms ☐ Myoclonus

Skeletal/Limb Abnormalities

☐ Club foot ☐ Contractures ☐ Hammer toe ☐ Painless foot ulcers
☐ Pes cavus ☐ Pes planus ☐ Scoliosis

Other Manifestations ☐ Other, specify:

At what age did symptoms present?

Has previous testing been performed for this patient? ☐ No ☐ Yes If Yes, complete information below.

☐ Sequencing for genes:

☐ Deletion/Duplication for genes:

☐ EMG/NCS (describe):

☐ Ulnar motor forearm nerve conduction velocity (m/s) and distal amplitude (mV) and/or R1 blink latency (ms):

☐ Imaging (ie, brain MRI):

☐ Muscle biopsy (describe):

☐ CK level (describe):

Family History

Are other relatives known to be affected? ☐ No ☐ Yes If Yes, indicate their relationship to the patient and list their symptoms:

Have other relatives had molecular genetic testing? ☐ No ☐ Yes If Yes, complete the information below:

Genes:

Mutations:

Name of individual tested *(Last, First, Middle)*:

Birth date of individual tested *(mm-dd-yyyy)*:

Laboratory at which testing was performed:

If testing is being performed for an asymptomatic individual due to a family history, note that pretest genetic counseling is strongly recommended.

Ethnic Background

☐ European Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other specify:

Print