Complete and print.

MAYO CLINIC LABORATORIES

Bruton Tyrosine Kinase (BTK) Gene Sequencing Patient Information

B T K G P T I N

Reset Form

Instructions: The 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 this 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: +1-507-266-5700 or email MLIINT@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 Provider Information (required)

Requesting Provider 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 (check all that apply)

☐ Diagnosis ☐ Family History** ☐ Carrier Screening**

☐ Other, specify:

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

Clinical History

Patient's clinical status: ☐ Asymptomatic ☐ Symptomatic ☐ Other:

Has the patient received immunoglobulin treatment? ☐ Yes ☐ No

Hypogammaglobulinemia (low IgG, IgM, IgA)	☐ Yes	☐ No	Sinusitis	☐ Yes	☐ No
Common Variable Immunodeficiency (CVID)	☐ Yes	☐ No	Tonsils present	☐ Yes	☐ No
Recurrent infections	☐ Yes	☐ No	Lymph nodes present	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No	Splenomegaly	☐ Yes	☐ No
CD19+ B-cells present in blood (>1%)	☐ Yes	☐ No			

Btk protein by flow cytometry ☐ Present ☐ Absent ☐ Equivocal ☐ Carrier ☐ Unknown

Other Diagnosis

Other Information (such as allogeneic stem cell transplant; indicate type [myeloablative vs. non-myeloablative] and date)

Family History

Normal	☐ Father	☐ Mother	☐ Siblings
Hypogammaglobulinemia (low IgG and/or IgM, IgA)	☐ Father	☐ Mother	☐ Siblings
CVID	☐ Father	☐ Mother	☐ Siblings
Recurrent infections	☐ Father	☐ Mother	☐ Siblings

Are other male relatives known to be affected? ☐ Yes ☐ No If "Yes," indicate their relationship to the patient:

Are other female relatives known to be a carrier? ☐ Yes ☐ No If "Yes," indicate their relationship to the patient:

Have other relatives had molecular genetics testing?*** ☐ Yes ☐ No If "Yes," indicate their relationship to the patient:

If the relative was tested at Mayo Clinic, include the name of the family member:

***FMTT / **Familial Variant, Targeted Testing** should be used when there is a previous positive genetic test result in the family. Contact the lab for ordering assistance.

Ancestry

☐ African/African American	☐ East Asian	☐ Latinx/Latine	☐ South Asian	☐ Choose not to disclose
☐ Ashkenazi Jewish	☐ European	☐ Middle Eastern	☐ None of the above	☐ Unknown

New York State Patients: Informed Consent for Genetic Testing is required.
See Informed Consent for Genetic Testing (T576) or Informed Consent for Genetic Testing – Spanish (T826).

Print