Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Hereditary Dyslipidemia Patient Information

Instructions: Accurate interpretation and reporting of genetic results is contingent upon the reason for testing, clinical information, ethnic background/ancestry, and family history. 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: +1-507-266-5700 or email MLIINT@mayo.edu**

Patient Information

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 Provider Information

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

☐ Diagnosis ☐ Family History** ☐ Other, specify:

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

Indications

☐ Familial hypercholesterolemia ☐ Hypertriglyceridemia ☐ Hypobetalipoproteinemia ☐ Familial lipodystrophy ☐ Sitosterolemia

Clinical History

Laboratory Findings

Cholesterol

- Total cholesterol: mg/dL **OR** mmol/L
- Low density cholesterol (LDL): mg/dL **OR** mmol/L
- High density cholesterol (HDL): mg/dL **OR** mmol/L
- Triglycerides: mg/dL **OR** mmol/L

Sterols

- Sitosterol: mg/dL
- Campesterol: mg/dL
- Other sterols:

Clinical Findings

☐ Tendon xanthomas
☐ Cutaneous xanthomas
☐ History of coronary artery disease
☐ History of myocardial infarction
☐ Lipodystrophy
☐ Generalized ☐ Partial
☐ Insulin resistance/Diabetes
☐ Non-alcoholic liver disease
☐ Kidney failure

Other Relevant Clinical History

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Hereditary Dyslipidemia Patient Information (continued)

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

Family History

Are there similarly affected relatives? ☐ Yes ☐ No

If "Yes," indicate relationship and symptoms:

Have any family member had genetic testing? ☐ Yes*** ☐ No ☐ 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: ☐ No ☐ Yes; relationship details:

Ancestry

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

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

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