Complete and print.

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 Mayo Clinic Laboratories, Attn: Molecular Genetics Lab Genetic Counselors at 507-284-1759.**

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

Referring 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

Study purpose: ☐ Diagnostic ☐ Presymptomatic/Family history

Working Clinical Diagnosis (describe)

Ethnic Background

☐ African American ☐ Asian ☐ Latinx ☐ Northern European
☐ Ashkenazi Jewish ☐ French Canadian ☐ Mixed European ☐ Southern European
☐ Indigenous; indicate tribe: _____ ☐ Other (specify): _____
☐ Choose not to disclose ☐ Unknown ☐ None of the above

Family History

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

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: _____

MC1235-235rev0423

Patient Information

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

Clinical Information Check all that apply **or** fax most recent clinic note.

Autonomic	☐ Abnormal sweating ☐ Dysphagia ☐ Shortness of breath ☐ Abnormal temperature regulation ☐ Orthostatic dizziness/fainting
Cardiac	☐ Abnormal heart rate ☐ Arrhythmia ☐ Cardiomyopathy ☐ Palpitations
Cognitive	☐ Behavioral changes ☐ Difficulty concentrating ☐ Intellectual disability ☐ Speech/Language difficulties ☐ Cognitive decline ☐ 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 ☐ Cyclic vomiting ☐ Incontinence ☐ Constipation ☐ Gastroparesis ☐ Loss of appetite
Muscular	☐ Easy fatigue ☐ Hypotonia ☐ Muscle wasting ☐ Myalgia ☐ Hypertonia ☐ Muscle stiffness ☐ Muscle weakness ☐ Myotonia
Neurological	☐ Abnormal balance ☐ Cerebellar atrophy ☐ Foot drop ☐ Paraplegia ☐ Rigidity ☐ Ataxia ☐ Chorea ☐ Gait abnormality ☐ Paresthesia ☐ Strokes ☐ Bradykinesia ☐ Dysarthria ☐ Hallucinations ☐ Poor coordination ☐ Tremor ☐ Brain malformation ☐ Dystonia ☐ Pain ☐ Recurrent headaches ☐ Deep tendon, check one: ☐ Absent ☐ Increased ☐ Decreased ☐ Vertigo ☐ Neuropathy, check one: ☐ Motor ☐ Sensory ☐ Sensorimotor ☐ Autonomic ☐ Weakness, check one: ☐ Distal ☐ Proximal
Psychiatric	☐ Mood changes ☐ Psychiatric disturbance/diagnosis ☐ Sleep disturbances
Seizures/Epilepsy	☐ Absence seizures ☐ Febrile seizures ☐ Generalized seizures ☐ Myoclonus ☐ Epileptic encephalopathy ☐ Focal seizures ☐ Infantile/Epileptic spasms
Skeletal/Limb Abnormalities	☐ Club foot ☐ Hammer toe ☐ Pes cavus ☐ Scoliosis ☐ Contractures ☐ Painless foot ulcers ☐ Pes planus
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: _____

☐ Electromyography/nerve conduction study (EMG/NCS); describe: _____

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

☐ Imaging [eg, brain magnetic resonance imaging (MRI)]: _____

☐ Muscle biopsy; describe: _____

☐ Creatine kinase (CK) level; describe: _____

Print