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MAYO CLINIC LABORATORIES

Hereditary Renal Genetic Testing Patient Information

Instructions: The accurate interpretation and reporting of the genetic results is contingent upon the reason for testing, indications, clinical history, family history, and ancestry. 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 Check all that apply.

☐ Diagnosis ☐ Presymptomatic diagnosis** ☐ Prenatal ☐ Family History** ☐ Transplant Evaluation
☐ 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 Check all that apply.

☐ **Alagille syndrome**
- ☐ Congenital heart defect
- ☐ Vertebral abnormalities
- ☐ Cholestasis
- ☐ Liver disease
- ☐ Elevated liver enzymes

☐ **Alport syndrome**
- ☐ Hematuria and/or proteinuria
- ☐ Hearing loss
- ☐ Glomerular basement membrane abnormalities
- ☐ Abnormal collagen IV staining

☐ **Complement defects**
- ☐ Thrombotic microangiopathy (TMA)/Atypical hemolytic uremic syndrome (aHUS)
- ☐ Thrombotic thrombocytopenic purpura (TTP)
- ☐ Complement 3 glomerulopathy (C3G)

☐ **Congenital anomalies of the kidney and urinary tract (CAKUT)**
- ☐ Renal agenesis/hypodysplasia
- ☐ Structural kidney/ureter abnormality; specify:
- ☐ Other; specify:

☐ **Cystic kidney disease**
- ☐ Autosomal dominant polycystic kidney disease (ADPKD)
- ☐ Polycystic kidney disease
  - ☐ Bilateral
  - ☐ Unilateral
  - ☐ Cysts per kidney: R L
- ☐ Liver cysts; number:
- ☐ Pancreas cysts; number:
- ☐ Nephronophthisis

☐ **FSGS/SRNS**
- ☐ Biopsy proven focal segmental glomerulosclerosis
- ☐ Steroid resistant nephrotic syndrome
- ☐ Fabry disease
- ☐ Other; specify:

☐ **Nephrolithiasis/Nephrocalcinosis**
- ☐ Kidney stones
  - Type:
  - Recurrent: ☐ Yes ☐ No
- ☐ Nephrocalcinosis

☐ **Bartter syndrome**
- ☐ Hypokalemic hypochloremic alkalosis
- ☐ Concentrating defect

☐ **Renal electrolyte abnormalities and related disorders**
- ☐ Gitelman syndrome
- ☐ Hypercalcemia
- ☐ Hypercalciuria
- ☐ Hypocalcemia
- ☐ Hypocalciuria
- ☐ Hypomagnesemia
- ☐ Hypophosphatasia/Hypophosphatemic rickets
- ☐ Hyperaldosteronism
- ☐ Liddle syndrome/Severe idiopathic hypertension
- ☐ Pseudohypoaldosteronism
- ☐ Renal tubular acidosis (proximal/distal)
- ☐ Other; specify:

☐ **Prenatal abnormalities**
- ☐ Polyhydramnios ☐ Hydronephrosis
- ☐ Oligohydramnios ☐ Echogenic kidney(s)
- ☐ Other; specify:

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Hereditary Renal Genetic Testing
Patient Information (continued)

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

Clinical History

General Renal History

- ☐ Hematuria
- ☐ Proteinuria
- ☐ Aminoaciduria
- ☐ Glucosuria
- ☐ Polyuria
- ☐ Oliguria
- ☐ Renal salt wasting
- ☐ Systemic lupus
- ☐ Diabetes
- ☐ Hypertension
- ☐ Acute kidney failure/injury
- ☐ Exposure to nephrotoxic medications
- ☐ Infectious disease; specify:

Extra-Renal Findings

- ☐ Intracranial aneurysm
- ☐ Retinitis pigmentosa or vision loss
- ☐ Heterotaxy
- ☐ Abnormal brain MRI; specify:
- ☐ Dysmorphic facial features; specify:
- ☐ Ear abnormalities; specify:
- ☐ Other; specify:

Other Clinical History

- ☐ History of kidney transplant
- ☐ History of immunosuppressive therapy
- ☐ History of allogeneic hematopoietic stem cell transplantation
- ☐ Other; describe:

Current Medications:

Laboratory Findings

Kidney Biomarkers

- ☐ eGFR/GFR:
- ☐ Creatinine clearance:
- ☐ TmP/GFR:
- ☐ Other; specify:

Urine; describe or attach results from any abnormal urine labs:

Pathology

- ☐ Kidney biopsy; describe or attach pathology results:

Complement Serology

☐ AH50:	☐ Normal	☐ Abnormal
☐ C3:	☐ Normal	☐ Abnormal
☐ C4:	☐ Normal	☐ Abnormal
☐ C5:	☐ Normal	☐ Abnormal
☐ CH50:	☐ Normal	☐ Abnormal
☐ Factor B:	☐ Normal	☐ Abnormal
☐ Factor D:	☐ Normal	☐ Abnormal
☐ Factor H:	☐ Normal	☐ Abnormal
☐ Factor I:	☐ Normal	☐ Abnormal
☐ FH antibodies:	☐ Absent	☐ Present

- ☐ Other; specify:

Soluble Biomarkers

- ☐ Shiga toxin: ☐ Positive ☐ Negative ☐ Unknown
- ☐ ADAMTS13: Activity %, Level

Blood; describe or attach results from any abnormal blood labs:

Patient Treatment History

Has the patient received an allogenic stem cell transplant***? ☐ No ☐ Yes; transplant date (mm-dd-yyyy):

Is the patient transfusion dependent***? ☐ No ☐ Yes; last transfusion date (mm-dd-yyyy):

Was this transfusion leukoreduced***? ☐ No ☐ Yes ☐ Unknown

***Results may be inaccurate due to the presence of donor DNA if the patient has received an allogeneic hematopoietic stem cell transplant or non-leukocyte reduced blood products. Call Mayo Clinic Laboratories for instructions for testing patient who have received a bone marrow transplant.

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Hereditary Renal Genetic Testing
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 members 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: ☐ Yes ☐ No If "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), Informed Consent for Genetic Testing – Spanish (T826).

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