Complete and print.

MAYO CLINIC LABORATORIES

Chromosomal Microarray Patient Information

Instructions: The accurate interpretation and reporting of genetic results is contingent upon the reason for referral, clinical information provided, and family history. Supply the information requested below and **send paperwork with the specimen or return by fax to Mayo Clinic Laboratories, Attn: Cytogenetics Lab Genetic Counselors at 507-284-1759. Phone: 507-266-5700 / International clients: +1-507-266-5700 or email mclglobal@mayo.edu.**

Reset Form

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	Email*	**Any communication sent via email will comply with applicable HIPAA regulations.*
Genetic Counselor Name *(Last, First)*	Phone	Email*	

Reason for Testing

Clinical Information Check all that apply.

Perinatal History
- ☐ Prematurity
- ☐ Intrauterine growth restriction (IUGR)
- ☐ Oligohydramnios
- ☐ Polyhydramnios
- ☐ Abnormal prenatal testing (include copy of report) _____
- ☐ Other: _____

Growth
- ☐ Failure to thrive
- ☐ Overgrowth
- ☐ Short stature
- ☐ Other: _____

Cognitive/Developmental
- ☐ Developmental delay
  - ☐ Fine motor delay
  - ☐ Gross motor delay
  - ☐ Speech delay
- ☐ Intellectual disability/MR
- ☐ Learning disability
- ☐ Other: _____

Behavioral/Psychiatric
- ☐ ADHD
- ☐ Autism
- ☐ Oppositional-defiant disorder
- ☐ Obsessive-compulsive disorder
- ☐ Pervasive developmental delay
- ☐ Other: _____

Cutaneous
- ☐ Hyperpigmentation
- ☐ Hypopigmentation
- ☐ Other: _____

Neurological
- ☐ Ataxia
- ☐ Cerebral Palsy
- ☐ Encephalopathy
- ☐ Hypotonia
- ☐ Hypertonia
- ☐ Seizures
- ☐ Spasticity
- ☐ Structural brain anomaly
- ☐ Other: _____

Cardiac
- ☐ Atrial septal defect
- ☐ Atrioventricular (AV) canal defect
- ☐ Tetralogy of Fallot
- ☐ Ventricular septal defect
- ☐ Other cardiac abnormality: _____

Craniofacial
- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Craniosynostosis
- ☐ Dysmorphic features
- ☐ Ear malformation
- ☐ Macrocephaly
- ☐ Microcephaly
- ☐ Other: _____

Hearing/Vision
- ☐ Abnormality of eye movement
- ☐ Abnormality of vision
- ☐ Hearing loss
- ☐ Other: _____

Musculoskeletal
- ☐ Club foot
- ☐ Contractures
- ☐ Diaphragmatic hernia
- ☐ Limb anomaly
- ☐ Polydactyly
- ☐ Syndactyly
- ☐ Vertebral anomaly
- ☐ Other: _____

Gastrointestinal
- ☐ Anal atresia
- ☐ Gastroschisis
- ☐ Omphalocele
- ☐ Pyloric stenosis
- ☐ Tracheoesophageal fistula
- ☐ Other: _____

Genitourinary
- ☐ Ambiguous genitalia
- ☐ Cryptorchidism
- ☐ Hydronephrosis
- ☐ Hypospadias
- ☐ Kidney malformation
- ☐ Other: _____

Family History
- ☐ Parents with 2 or more miscarriages
- ☐ Other relatives with similar clinical history (explain below):

Clinical Descriptions Include any additional relevant clinical information. List all previous genetic testing and provide a report.

Print