Complete and print.

MAYO CLINIC LABORATORIES

CYP21A2 Gene Testing for Congenital Adrenal Hyperplasia Patient Information

C Y P 2 1 A 2

Reset Form

Instructions: Accurate interpretation and reporting of the genetic results is contingent upon the reason for referral, clinical information, ancestry, and family history. To help provide the best possible service, supply the information requested below and **send a completed copy of this form with the specimen.**

Patient Information (required)

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*
Other Contact Name *(Last, First)*	Phone	Fax*

**Fax number given must be from a fax machine that complies with applicable HIPAA regulations.*

For diagnostic testing or carrier screening on whole blood, order test code CYPZ / 21-Hydroxylase Gene (CYP21A2), Full Gene Analysis, Varies.

Note:
- Due to the complexity of *CYP21A2* testing, known mutation testing is not available. If familial mutations have been previously identified in this family, provide this information in the Family History section below and attach any available laboratory test reports from family members.
- For prenatal specimens, order CYPZ / 21-Hydroxylase Gene (CYP21A2), Full Gene Analysis, Varies.

Reason for Testing

☐ Diagnosis or Suspected Diagnosis (Indicate relevant information in the Clinical History section below.)
☐ Prenatal (Indicate relevant information in the Clinical History section below.)
☐ Carrier Screening:
- ☐ Family history of the condition, specify:
- ☐ Partner has a family history of the condition
- ☐ Partner is a carrier of the condition
- ☐ Partner is affected with the condition
- ☐ Other reproductive risk assessment, specify:

Pertinent Clinical and Laboratory History Check all that apply.

☐ Ambiguous genitalia detected on prenatal ultrasound
☐ Positive newborn screen for CAH (Congenital Adrenal Hyperplasia)
☐ Elevated 17-OHP
☐ Chromosome analysis performed, indicate patient's karyotype: ☐ 46, XX ☐ 46, XY ☐ Other, specify:
☐ History of salt-wasting
☐ Precocious puberty or virilization, specify:

Other Information (eg, specific prenatal findings)

Ancestry Ancestry may assist with interpretation of test results.

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

Family History

Are other relatives known to be affected? ☐ Yes ☐ No	If Yes, indicate their relationship to the patient.
Are other relatives known to be a carrier? ☐ Yes ☐ No	If Yes, indicate their relationship to the patient.
Have other relatives had molecular genetic testing? ☐ Yes ☐ No	If Yes, indicate familial mutations and attach a copy of the family member's lab report.
If the relative was tested at the Mayo Clinic, include the name of the family member:	

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).

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