



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

Form with fields for Patient Name (Last, First Middle), Birth Date (mm-dd-yyyy), Sex Assigned at Birth (Male, Female, Unknown, Choose not to disclose), and Legal/Administrative Sex (Male, Female, Nonbinary).

Referring Provider Information

Form with fields for Requesting Provider Name (Last, First), Phone, Fax*, Genetic Counselor Name (Last, First), and another Phone/Fax* field.

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

Reason for Testing

Form with checkboxes for Diagnosis, Family History**, and Other, specify: followed by a text field. Below is a note: **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.

Clinical History

Form divided into Clinical Findings and Laboratory Findings. Clinical Findings includes checkboxes for Situs abnormality, Chronic nasal congestion, Chronic sinusitis, Pulmonary disease, Chronic or recurrent ear infections, and Infertility. Laboratory Findings includes checkboxes for Abnormal ciliary ultrastructure, Abnormal ciliary motility, and Low nasal nitric oxide. Other Relevant Clinical History section has multiple blank lines.

Family History

Form with questions: Are there similarly affected relatives? (Yes/No), Have any family member had genetic testing? (Yes***/No/Unknown), and History of consanguinity: (No/Yes; relationship details:).

Ancestry

Form with checkboxes for various ancestry categories: African/African American, Ashkenazi Jewish, East Asian, European, Latinx/Latine, Middle Eastern, South Asian, None of the above, and Unknown/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).