

# Molecular Genetics: Congenital Inherited Diseases Patient Information

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 the Molecular Genetics Laboratory 507-284-0670.**

## Patient Information

Patient Name <i>(Last, First, Middle)</i>	Birth Date <i>(Month DD, YYYY)</i>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Referring Physician <i>(Last, First)</i>	Phone	Fax*
Genetic Counselor	Phone	Fax*

\*Fax number provided must be from a fax machine that complies with applicable HIPAA regulation.

## Reason for Testing

<input type="checkbox"/> <b>CARRIER SCREEN - Check appropriate box</b> <input type="checkbox"/> Clinically normal individual with no family history of the condition <input type="checkbox"/> Family history of the condition <input type="checkbox"/> Spouse has family history of the condition		<input type="checkbox"/> Spouse is a carrier of the condition <input type="checkbox"/> Anonymous egg or sperm donor	
<input type="checkbox"/> <b>DIAGNOSIS OR SUSPECTED DIAGNOSIS</b> List all relevant clinical symptoms:			

**Ethnic Background** – *Ethnic background is necessary to provide appropriate interpretation of test results. Check appropriate box Especially important for Cystic Fibrosis testing.*

<input type="checkbox"/> Northern European Caucasian	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Ashkenazi Jewish	<input type="checkbox"/> Southern European Caucasian
<input type="checkbox"/> Mixed European Caucasian	<input type="checkbox"/> Asian	<input type="checkbox"/> French Canadian	<input type="checkbox"/> African American
<input type="checkbox"/> Caucasian - Indicate countries of origin: _____		<input type="checkbox"/> Other (specify): _____	

## Pregnancy Information

Is the patient or partner currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many weeks gestation?: _____
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## Family History

Are other relatives known to be affected? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, indicate their relationship to the patient: _____
Are other relatives known to be carrier? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, indicate their relationship to the patient: _____
Have other relatives had molecular genetic testing? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, complete the information below:
Gene: _____ Name and date of birth of individual tested: _____
Mutations: _____ Laboratory at which testing was performed: _____