Complete all information below. Send paperwork with the specimen or return by fax to MCL Biochemical Genetics Laboratory, **507-266-2888**. For questions or additional assistance, call 800-533-1710 and ask for the on-call Biochemical Genetics Counselor.

MAYO CLINIC LABORATORIES

Patient Information						
Patient Name (Last, First, Middle)				Birth Date (mm-dd-yyyy)	Sex	
					🗆 Male 🗆 Female	
Referring Provider Name (Last, First)				Phone	Fax*	
Genetic Counselor Name (Last, First)				Phone	Fax*	
		*Fax	number aive	en must be from a fax machine	that complies with applicable HIPAA regulat	
Reason for Testing Do not use	e this form for prenatal te					
□ Positive newborn screen for:				□ Rule out:		
Monitor Treatment:	□ Family History:			□ Carrier Screening:		
Specimen Information						
Date Today (mm-dd-yyyy)			Collectio	n Date <i>(mm-dd-yyyy)</i>		
Clinical Information						
List all relevant clinical information and			•	• • •		
□ Current acute illness □ Chronic symptoms □ Intermittent symptoms, currently well						
Current medications and diet:						
If this is for carrier screening, were ora						
Is the patient or partner currently pregi	nant?	□ Yes		If yes, how many we	eks gestation?	
Family History						
Ethnic background of patient:						
Are there any other individuals diagnos	ed with or suspected of	having th	is conditio	on? 🗆 Yes 🗆 No		

List all relevant clinical information and the results of any applicable testing (screening and diagnostic) for each individual and include whether they are living or deceased: