

Cytogenetics – Array CGH Testing Patient Information Sheet

Instructions: The accurate interpretation and reporting of genetic results is contingent upon the reason for referral, clinical information provided, 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 the Cytogenetics Laboratory, attn: Genetic Counselors, 507-284-0043 (phone 507-538-2952).**

Patient Name (<i>Last, First, Middle</i>)	Birth Date (<i>Month DD, YYYY</i>)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Clinical Information – check all that apply

<p>Perinatal History</p> <p><input type="checkbox"/> Prematurity</p> <p><input type="checkbox"/> IUGR</p> <p><input type="checkbox"/> Oligohydramnios</p> <p><input type="checkbox"/> Polyhydramnios</p> <p><input type="checkbox"/> Other: _____</p> <p>Growth</p> <p><input type="checkbox"/> Failure to thrive</p> <p><input type="checkbox"/> Overgrowth</p> <p><input type="checkbox"/> Short stature</p> <p><input type="checkbox"/> Other: _____</p> <p>Development</p> <p><input type="checkbox"/> Fine motor delay</p> <p><input type="checkbox"/> Gross motor delay</p> <p><input type="checkbox"/> Speech delay</p> <p><input type="checkbox"/> Other: _____</p> <p>Cognitive</p> <p><input type="checkbox"/> Learning disability</p> <p><input type="checkbox"/> Mental retardation</p> <p>List IQ/DQ, if known: _____</p> <p><input type="checkbox"/> Other: _____</p> <p>Behavioral</p> <p><input type="checkbox"/> Autistic features</p> <p><input type="checkbox"/> Autism spectrum disorder</p> <p><input type="checkbox"/> Oppositional-defiant disorder</p> <p><input type="checkbox"/> Obsessive-compulsive disorder</p> <p><input type="checkbox"/> Other: _____</p>	<p>Neurological</p> <p><input type="checkbox"/> Ataxia</p> <p><input type="checkbox"/> Chorea</p> <p><input type="checkbox"/> Dystonia</p> <p><input type="checkbox"/> Hypotonia</p> <p><input type="checkbox"/> Neural tube defect</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Spasticity</p> <p><input type="checkbox"/> Structural brain anomaly</p> <p><input type="checkbox"/> Other: _____</p> <p>Cardiac</p> <p><input type="checkbox"/> ASD</p> <p><input type="checkbox"/> AV canal defect</p> <p><input type="checkbox"/> Coarctation of aorta</p> <p><input type="checkbox"/> Hypoplastic left heart</p> <p><input type="checkbox"/> Tetralogy of Fallot</p> <p><input type="checkbox"/> VSD</p> <p><input type="checkbox"/> Other: _____</p> <p>Craniofacial</p> <p><input type="checkbox"/> Cleft lip</p> <p><input type="checkbox"/> Cleft palate</p> <p><input type="checkbox"/> Coloboma of eye</p> <p><input type="checkbox"/> Craniosynostosis</p> <p><input type="checkbox"/> Dysmorphic facial features</p> <p><input type="checkbox"/> Ear malformation</p> <p><input type="checkbox"/> Macrocephaly</p> <p><input type="checkbox"/> Microcephaly</p> <p>List HC, if known: _____</p> <p><input type="checkbox"/> Other: _____</p> <p>Cutaneous</p> <p><input type="checkbox"/> Hyperpigmentation</p> <p><input type="checkbox"/> Hypopigmentation</p> <p><input type="checkbox"/> Other: _____</p>	<p>Musculoskeletal</p> <p><input type="checkbox"/> Contractures</p> <p><input type="checkbox"/> Club foot</p> <p><input type="checkbox"/> Diaphragmatic hernia</p> <p><input type="checkbox"/> Limb anomaly</p> <p><input type="checkbox"/> Polydactyly</p> <p><input type="checkbox"/> Scoliosis</p> <p><input type="checkbox"/> Syndactyly</p> <p><input type="checkbox"/> Vertebral anomaly</p> <p><input type="checkbox"/> Other: _____</p> <p>Gastrointestinal</p> <p><input type="checkbox"/> Gastroschisis</p> <p><input type="checkbox"/> Hirschsprung disease</p> <p><input type="checkbox"/> Omphalocele</p> <p><input type="checkbox"/> Pyloric stenosis</p> <p><input type="checkbox"/> Tracheoesophageal fistula</p> <p><input type="checkbox"/> Other: _____</p> <p>Genitourinary</p> <p><input type="checkbox"/> Ambiguous genitalia</p> <p><input type="checkbox"/> Hydronephrosis</p> <p><input type="checkbox"/> Hypospadias</p> <p><input type="checkbox"/> Kidney malformation</p> <p><input type="checkbox"/> Undescended testis</p> <p><input type="checkbox"/> Urethral obstruction</p> <p><input type="checkbox"/> Ureteral obstruction</p> <p><input type="checkbox"/> Other: _____</p> <p>Family History</p> <p><input type="checkbox"/> Parents with ≥ 2 miscarriages</p> <p><input type="checkbox"/> Other relatives with similar clinical history (explain below)</p>
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Clinical Descriptions – include any additional relevant clinical information not provided above (list karyotype if known and provide a report):

As a participant in the ISCA (International Standards for Cytogenomic Arrays) Consortium, Mayo Clinic Cytogenetics Laboratory contributes submitted clinical information and test results to a HIPAA-compliant, de-identified public database as part of the NIH's effort to improve our understanding of the relationships between genetic changes and clinical symptoms. Confidentiality is maintained. Patients may request to opt-out of this scientific effort by: 1) checking the box below, 2) calling the laboratory at **1-800-533-1710, extension 8-2952** and asking to speak with a laboratory genetic counselor. Please call with any questions.

Refusal for inclusion in these efforts may be indicated by checking this box. (If the box is not marked, the data will be anonymized and submitted.)