MAYO CLINIC
Mayo Medical Laboratories

SDHB, SDHC, SDHD Gene Testing Patient Information Sheet

Instructions: The accurate interpretation and reporting of the genetic results is contingent upon the reason for referral, clinical information, ethnic background, and family history. To help provide the best possible service, please supply the information requested below and **send paperwork with the specimen.**

Patient Information

Patient Name – First Name, Middle Initial, Last Name	Birth Date *(Month DD, YYYY)*	Age	Sex ☐ Male ☐ Female

Referring Physician Name	Phone Number	Fax Number
Other Contact	Phone Number	Fax Number

Purpose of Study

Clinical status: ☐ Symptomatic ☐ Asymptomatic
Purpose of Study: ☐ Diagnostic ☐ Presymptomatic

SDH Known Mutation *(if applicable)*

If 89554 SDH Known Mutation is ordered, the following information must be provided or testing cannot be completed:
- Known familial mutation to be analyzed: ☐ SDHB ☐ SDHC ☐ SDHD
  Exon_____ Nucleotide_____ Amino Acid_____ **OR** Intron_____ Nucleotide_____
- Proband's relationship to this patient:

SDH Deletion Detection *(if applicable)*

If 89555 SDH Deletion is ordered, the following information must be provided or testing cannot be completed:
- Known familial deletion to be analyzed: ☐ SDHB ☐ SDHC ☐ SDHD Exon_____
- Proband's relationship to this patient:

Pertinent Clinical and Laboratory History *(check all that apply)*

Paraganglioma(s)? ☐ Yes ☐ No If yes, number and location:		
Pheochromocytoma(s)? ☐ Yes ☐ No If yes, unilateral or bilateral? ☐ Unilateral ☐ Bilateral		
Renal Cell Carcinoma? ☐ Yes ☐ No	Other tumors? ☐ Yes ☐ No If yes specify_____	
Hypertension? ☐ Yes ☐ No	Headaches? ☐ Yes ☐ No	Profuse sweating? ☐ Yes ☐ No
Palpitations? ☐ Yes ☐ No	Anxiety? ☐ Yes ☐ No	
List supporting biochemical test results:		
Other Relevant Clinical Information (surgeries, malignancy, etc.):		

Ethnic Background - *Ethnic background is necessary to provide appropriate interpretation of test results.*

☐ European Caucasian	☐ African American	☐ Hispanic
☐ Asian	☐ Other (specify):	
Please indicate countries of origin:		

Family History

Are other relatives known to be affected? ☐ Yes ☐ No	If yes, indicate their relationship to the patient:
Have other relatives had molecular genetic testing for SDHB, SDHC, or SDHD? ☐ Yes ☐ No If yes, which gene? _____	If yes, please indicate the performing laboratory and attach a copy of the genetic test lab report if available:
If the relative was tested at Mayo Clinic, include the name of the family member:	
Please include a detailed pedigree, if available.	

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