

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, supply the information requested below and **send paperwork with the specimen.**

Patient Information

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

Treatment History

Immunoglobulin replacement therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Clinical History (*Check all that apply*)

Selective IgA deficiency (sIgAD) only? <input type="checkbox"/> Yes <input type="checkbox"/> No	Autoimmune thyroiditis? <input type="checkbox"/> Yes <input type="checkbox"/> No
Hypogammaglobulinemia (low IgG and/or IgM, IgA)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other autoimmunity? <input type="checkbox"/> Yes <input type="checkbox"/> No
Common variable immunodeficiency (CVID)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillar hypertrophy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Recurrent infections? <input type="checkbox"/> Yes <input type="checkbox"/> No	Lymphadenopathy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Splenomegaly? <input type="checkbox"/> Yes <input type="checkbox"/> No	Non-Hodgkin's lymphoma? <input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune hemolytic anemia? <input type="checkbox"/> Yes <input type="checkbox"/> No	GI complications? <input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune thrombocytopenia? <input type="checkbox"/> Yes <input type="checkbox"/> No	Solid tumors? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other diagnosis:	Other hematological neoplasias? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other information (such as stem cell transplant for lymphoma-indicate type and date)	
Ethnic Background - <i>Ethnic background may assist with interpretation of test results.</i>	
<input type="checkbox"/> European/Caucasian (<i>List countries of origin</i>) _____	
<input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other (<i>specify</i>) _____	

Family History

Normal	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling(s)
sIgAD Only	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling(s)
Hypogammaglobulinemia (low IgG and/or IgM, IgA)	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling(s)
CVID	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling(s)
CVID + IgA deficiency	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling(s)
Recurrent infections	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling(s)
Are other relatives known to be affected? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate their relationship to the patient:		
Are other relatives known to be a carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate their relationship to the patient:		
Have other relatives had molecular genetics testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate their relationship to the patient:		
If the relative tested at Mayo Clinic, include the name of the family member			