

# Biochemical Genetics – Respiratory Chain Complex Patient Information

**Instructions:** 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, please supply the information requested below and **send paperwork with the specimen or return by fax to Laboratory Genetics 507-266-2888 (phone 800-533-1710).**

Patient Name		Birth Date (Month, DD, YYYY)
Requesting Physician Name	Phone Number	Fax Number
Sample Type <input type="checkbox"/> Fibroblasts <input type="checkbox"/> Muscle	Collection Date (Month, DD, YYYY)	Mayo Medical Laboratories Account No.

## Brief Clinical Summary

## Current Medications and Diet

## Clinical Findings (check all that apply; please provide details)

<input type="checkbox"/> Dysmorphic Features	<input type="checkbox"/> Vision Abnormalities	<input type="checkbox"/> Movement Disorder	<input type="checkbox"/> Renal Abnormalities
<input type="checkbox"/> Microcephaly	<input type="checkbox"/> Retinopathy	<input type="checkbox"/> Abnormal DTRs	<input type="checkbox"/> Renal Failure
<input type="checkbox"/> Macrocephaly	<input type="checkbox"/> Optic Atrophy	<input type="checkbox"/> Gastrointestinal Abnormality	<input type="checkbox"/> FSGS
<input type="checkbox"/> Skin/Hair Abnormalities	<input type="checkbox"/> Hearing Abnormalities	<input type="checkbox"/> Vomiting/Formula Intolerance	<input type="checkbox"/> Cardiac Abnormality
<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Anatomic Brain Defect	<input type="checkbox"/> Abnormal GI Motility	<input type="checkbox"/> Cardiac Conduction Defect
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Seizures	<input type="checkbox"/> Malabsorption	<input type="checkbox"/> Cardiomyopathy
<input type="checkbox"/> Neurodegeneration	<input type="checkbox"/> Coma/Lethargy	<input type="checkbox"/> Hepatomegaly	<input type="checkbox"/> Unusual Odor
<input type="checkbox"/> Muscle Myopathy	<input type="checkbox"/> Hypotonia	<input type="checkbox"/> Splenomegaly	<input type="checkbox"/> Family History
<input type="checkbox"/> Weakness/Fatigue	<input type="checkbox"/> Hypertonia	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Family History Unexplained
<input type="checkbox"/> Exercise Intolerance	<input type="checkbox"/> Ataxia	<input type="checkbox"/> Respiratory Abnormality	<input type="checkbox"/> Infant Death
<input type="checkbox"/> Rhabdomyolysis			<input type="checkbox"/> Family History Consanguinity

Details/Other \_\_\_\_\_

## Lab Findings (check all that apply; please provide details)

<input type="checkbox"/> Acidosis	<input type="checkbox"/> Ketosis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Abnormal Amino Acids
<input type="checkbox"/> Lactic Acidosis	<input type="checkbox"/> Hyperammonemia	<input type="checkbox"/> Thrombocytopenia	<input type="checkbox"/> Abnormal Acylcarnitines
<input type="checkbox"/> Abnormal L:P Ratio	<input type="checkbox"/> Hyperglycemia	<input type="checkbox"/> Myoglobinuria	<input type="checkbox"/> Abnormal Organic Acids
<input type="checkbox"/> Abnormal Anion Gap	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Abnormal CSF (Lact, Prot)	

Details/Other \_\_\_\_\_

## Additional Workup (check abnormal/normal; please provide details)

BAER	<input type="checkbox"/> Abn <input type="checkbox"/> Norm	MRSpec	<input type="checkbox"/> Abn <input type="checkbox"/> Norm	Tissue Studies	Genetic Studies
VER	<input type="checkbox"/> Abn <input type="checkbox"/> Norm	X-rays	<input type="checkbox"/> Abn <input type="checkbox"/> Norm	Fibroblast	Chromosome
EMG	<input type="checkbox"/> Abn <input type="checkbox"/> Norm	U/S	<input type="checkbox"/> Abn <input type="checkbox"/> Norm	Muscle	FISH
EEG	<input type="checkbox"/> Abn <input type="checkbox"/> Norm	Echo	<input type="checkbox"/> Abn <input type="checkbox"/> Norm		
MRI	<input type="checkbox"/> Abn <input type="checkbox"/> Norm	EKG	<input type="checkbox"/> Abn <input type="checkbox"/> Norm		
CT	<input type="checkbox"/> Abn <input type="checkbox"/> Norm				

Details/Other \_\_\_\_\_