

The accurate interpretation and reporting of the genetic results is contingent upon the reason for testing, 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 - Last Name	First Name	Middle Initial	Gender	Birth Date
Referring Physician Name	Phone Number		Fax Number*	
Other Contact	Phone Number		Fax Number*	

*Fax number given must be from a fax machine that complies with applicable HIPAA regulation.

Clinical History (check all that apply)

Treatment History			
Immunoglobulin replacement therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Clinical History			
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 - Ethnic background is necessary to provide appropriate interpretation of test results.

Caucasian: Mixed European Northern European Southern European

List countries of origin:

African American Asian French Canadian

Hispanic Other

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:			