MAYO CLINIC
Mayo Medical Laboratories

MayoConnect Additional Test Information

Surgical, Dermatology, Hematopathology, Laboratory Genetics

See reverse side for AFP, Coagulation, and Microbiology Testing

FOR ALL TESTS provide the following

Patient Name	Patient Identification Number
Referring Physician Name	Phone Number *(Include area code)*

Attach bar-coded patient label here.

HEMATOPATHOLOGY – Include the following information and send a copy of Bone Marrow and/or Blood Smear reports

Specimen Submitted

Patient's Ethnic or Racial Background

Recent Transfusion History

Is there a family history?
☐ Yes ☐ No ☐ Unknown

Is there a history of Splenomegaly?
☐ Yes ☐ No ☐ Unknown

CBC RESULTS:

HB _____ MCV _____

HCT _____ WBC _____

RBC _____ PLT _____

Reticulocyte Count *(if available)* _____

Check appropriate statement:

☐ Acute Lymphoblastic Leukemia
☐ Chronic Lymphocytic Leukemia
☐ Acute Myeloid Leukemia
☐ Chronic Myelogenous Leukemia
☐ Chronic Myeloproliferative Disease
☐ Lymphoma
☐ Plasma Cell Proliferative Disease
☐ Other: _____

Pertinent Clinical Information

DERMATOLOGY
8041 Cutaneous Immunofluorescence, Biopsy

Biopsy Site

Clinical Impression

Check One: ☐ Lesional (Involved) ☐ Perilesional ☐ Uninvolved

Check One: ☐ Sun Exposed ☐ Non-Sun Exposed

SURGICAL CONSULTATION – Include a brief history, pertinent lab results and suspected diagnosis or indicate in space provided below

Tissue Source	Patient Birth Date *(Month DD, YYYY)*

Specimen Sent *(check all that apply)*

☐ Fixed Formalin ☐ Paraffin Block(s), Number Sent: _____
☐ Frozen Tissue ☐ Slide(s), No. Sent: _____
☐ Gluteraldehyde ☐ Zeus Media
☐ Wet Tissue ☐ Other: _____

Pathologist/Clinical Diagnosis *(or send copy of pathology report)*

LABORATORY GENETICS – Biochemical Genetics, Cytogenetics*

Denotes the only information required for Cytogenetics testing.

*Reason for Ordering Test(s)	*Relevant Clinical Information

Is there a family history of a similar condition?
☐ Yes ☐ No ☐ Unknown

Has the patient or a family member had this test before?
☐ Yes ☐ No ☐ Unknown

If yes to either of the above questions, complete the following (if more than two individuals, list on additional sheet of paper):

Relationship to Patient	Affected	Carrier	Test Result(s)	Check if Tested at Mayo	Name (Optional)
	☐	☐		☐	
	☐	☐		☐	

Patient's Ethnic or Racial Background

Is patient currently pregnant?
☐ Yes ☐ No

If yes, complete the following: Estimated Gestational Age_____ Weeks on (Date)_____
By: ☐ LMP ☐ Ultrasound ☐ Physical Exam

ADDITIONAL INFORMATION for Biochemical Genetics Tests

Current Medications/Diet
☐ Valproic Acid ☐ Carbamazepine ☐ Carnitine ☐ Oral Contraceptives ☐ TPN ☐ Special Diet
☐ Other (specify):

Check if Applicable
☐ Acute Illness ☐ Asymptomatic ☐ Follow-Up *(specify disorder above)*
☐ Repeat Specimen *(specify previous findings above)* ☐ Post-Mortem Specimens

NEW YORK STATE PATIENTS: INFORMED CONSENT APPLICABLE TO HIV AND GENETIC TESTING

The client submitting this request has received reasonable assurance from the ordering physician that the above named New York State patient has given informed consent for the HIV and/or genetic testing ordered and that the patient authorizes MML to report such test results directly to the ordering physician.

(See reverse side)

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AFP, Coagulation, Microbiology

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FOR AFP AND COAGULATION TESTING provide the following

Patient Name	Patient Identification Number
Referring Physician Name	Phone Number *(Include area code)*

Attach bar-coded patient label here.

SECOND TRIMESTER SCREENING (QUAD, MAFP) – The following 10 questions MUST be completed for Second Trimester Screening

1	**Serum Collection Date** *(Month DD, YYYY)*	**7**	**In-Vitro Fertilization (IVF) Pregnancy** ☐ Yes ☐ No *(The age of the egg affects the risk calculations).* If egg donor *(other than patient)*, need donor birth date *(Month DD, YYYY)* _____ If frozen egg or embryo used, how long was egg or embryo frozen _____*(Years)* _____ *(Months)*
2	**Birth Date** *(Month DD, YYYY)*		
3	**Weight** lbs_____ or _____kg	**8**	**Previous pregnancy with Down Syndrome (Trisomy 21) or other Trisomy?** ☐ Yes ☐ No
4	**Insulin Dependent Diabetic** ☐ Yes ☐ No	**9**	**Is this a repeat visit?** ☐ Yes ☐ No If yes, list previous control number_____
5	**Race** ☐ Black ☐ Other/Non-Black/Mixed	**10**	**Gestational Information**: **EDD** ***(Month DD, YYYY)***_____ **by** ☐ **Ultrasound or** ☐ **LMP** If LMP is unknown and ultrasound has not been performed, provide other dating, such as physical exam or IVF. Please be specific.
6	**Twin Pregnancy** *(US EDD required)* ☐ Yes ☐ No		

COAGULATION

Identify the coagulation diagnostic concern of other relevant information:

Coagulation-related TESTING RESULTS from referring laboratory

PT _____ Normal Range _____

APTT _____ Normal Range _____

Platelet Count _____ Hematocrit_____

Other _____

Does the patient have:

Known congenital coagulation factory deficiency? ☐ Yes ☐ No

If yes, which factor? _____

Known coagulation factor inhibitor? ☐ Yes ☐ No

(If type of inhibitor is unknown we suggest ordering consult #553)

If yes, which factor? _____

Coagulation-related MEDICATION, current or past 7 days?

☐ Coumadin (Warfarin) ☐ Vitamin K

☐ Heparin (Unfractionated) ☐ Low Molecular Weight Heparin

☐ Lepirutin (Refludan) ☐ Thrombolytic (t-PA)

☐ Fondaparinux (Arixtra) ☐ Argatroban

Transfusion of Factor Replacement, past 72 hours? ☐ Yes ☐ No

Factor Concentrate – Specify product_____

☐ DDAVP ☐ Cryroprecipitate ☐ Fresh Frozen Plasma

For DNA Based Testing, has patient had:

Transfusion within the past 3 months? ☐ Yes ☐ No

Bone marrow transplant? ☐ Yes ☐ No

Liver transplant? ☐ Yes ☐ No

von Willebrand Testing Information

Ristocetin Cofactor Activity _____ Normal _____

Factor VIII Activity Results _____ Normal _____

von Willebrand Factor Ag Result _____ Normal _____

MICROBIOLOGY

Isolated Organism Referred for Identification – *All of the following information must be submitted to obtain identification of any organism submitted*		**Antimicrobial Susceptibility**
Source		Source
Number of times isolated from different specimens (same patient)		Organism Identification – *(If not known, add appropriate ID test)*
Recovery Medium	Transport Medium	Antibiotic to be Tested *(if applicable)*
Description (Gram Reaction, Morphology, Tests Performed)		
Extent of Identification Request		