MAYO CONNECT ADDITIONAL TEST INFORMATION

Surgical, Dermatology, Hematopathology, Laboratory Genetics
(See reverse side for AFP, Coagulation, and Microbiology Testing)

FOR ALL TESTS, please provide:

Attach bar-coded patient label here.

Referring Physician Name: _____
Referring Physician Phone Number: (_____)_____

DERMATOLOGY
8041 Cutaneous Immunofluorescence, Biopsy

Biopsy Site: _____ Clinical Impression: _____
Check appropriate statements below:
Check one: ☐ Lesional (involved) ☐ Perilesional ☐ Uninvolved Check one: ☐ Sun Exposed ☐ Non-Sun Exposed

HEMATOPATHOLOGY

Please include the following information and send a copy of Bone Marrow and/or Blood Smear reports.

Specimen submitted: _____

CBC results:
HB _____
WBC _____
PLT _____
MCV_____

Check appropriate statement below:
☐ Acute Lymphocytic Leukemia
☐ Chronic Lymphocytic Leukemia
☐ Acute Nonlymphocytic Leukemia
☐ Hairy Cell Disease
☐ Lymphoma

Pathologist/Clinical Diagnosis: _____
_____

SURGICAL CONSULTATION

Please include a brief history, pertinent laboratory results and suspected diagnosis or indicate in space provided below:

Patient Date of Birth: _____
Tissue Source: _____
Check specimen sent:
☐ Fixed Formalin ☐ Paraffin Block(s), No. sent ____
☐ Frozen tissue ☐ Slide(s), No. sent _____
☐ Gluteraldehyde ☐ Zeus Media
☐ Wet Tissue ☐ Other _____

Pathologist/Clinical Diagnosis: _____
_____

LABORATORY GENETICS (Biochemical Genetics, Cytogenetics, Molecular Genetics)
Reason for ordering test(s): _____
Relevant clinical information: _____
_____

Is there a history of this condition in the patient's family? ☐ Yes ☐ No
Has the patient or a family member has this test before? ☐ Yes ☐ No
If yes, to either question, please indicate:

Relationship to patient	**Affected**	**Carrier**	**Test Results**	**Check if Tested at Mayo**	**Name** (optional)
_____	☐	☐	_____	☐	_____
_____	☐	☐	_____	☐	_____

*If more than two individuals, please list on additional sheet of paper.

Patient's ethnic or racial background: _____
Is patient currently pregnant: ☐ yes If yes, Estimated gestational age: ____ weeks on date: ___ by: LMP or Ultrasound (circle)
☐ no

Additional Information For Biochemical Genetics tests:
Current Medications/Diet: _____Valproic Acid _____Carbamazepine _____Carnitine ____TPN ____Special Diet
_____Other (specific): _____
Please check if applicable: ____Acute Illness ____Asymptomatic ____Follow-up (specify disorder above)
____Repeat specimen (specify previous findings above) ____ Post-mortem specimen(s)

VERIFICATION OF INFORMED CONSENT (A REQUIREMENT FOR NEW YORK STATE PATIENTS)

Physician: I am a physician counseling the patient named above. I have obtained the informed consent of the patient for each genetic test(s) ordered above and authorize the testing of the enclosed specimen(s).

Signature of Physician Date

Patient: I have been informed of the nature and limitations of each genetic test requested on this form and give my permission to the above-named physician to send my specimen(s) to Mayo Medical Laboratories for testing. I authorize Mayo Medical Laboratories to report the results to the above-named physician.

Signature of Patient Date

MAYO CONNECT ADDITIONAL TEST INFORMATION

AFP, Coagulation, Microbiology

(See reverse side for Surgical, Dermatology, Hematophathology, & Laboratory Genetics)

Attach bar-coded patient label here.

AFP

Collection Date: _____/_____/_____ (mm/dd/yyyy)
Maternal Birth date: _____/_____/_____ (mm/dd/yyyy)

Race: ☐ Black ☐ Other

Insulin Dependant Diabetic? ☐ Yes ☐ No
Maternal Weight : _____Kg or _____lbs
Number of fetuses present: _____ (enter number)
Is this a repeat visit? ☐ Yes ☐ No
If yes, please note previous control number _____

Gestational Age Calculation: Multiple fetuses require ultrasound confirmation and gestational dating.

Complete <u>at lease one</u> of the following:

Gestation age by ultrasound:
_____weeks _____ days on ____/____/____ (mm/dd/yyyy)
(DO NOT extrapolate to collection date)

Last Menstrual period: ____/____/____ (mm/dd/yyyy)

Gestational age by physical exam: ____/____/____ (mm/dd/yyyy)

COAGULATION

Referring physician Name: _____
Referring Physician Phone Number: (_____)_____
Identify the coagulation diagnostic concern or other relevant information:
_____
_____

Coagulation-related testing results from referring laboratory:
PT _____ (normal range: _____)
PTT _____ (normal range: _____)
Platelet Count: _____ Hematrocrit: _____
Bleeding Time: _____ (normal range: _____)
Other: _____

Transfusion of Factor replacement, past 72 hours?
Check if applies: ☐ DDAVP ☐ Cryroprecipitate ☐ Fresh frozen plasma

Coagulation-related medication, current or past 7 days?
check of applies:
☐ Coumadin (warfarin) ☐ Low molecular weight heparin
☐ Heparin (unfractionated) ☐ Vitamin K
☐ Thrombolytic (t-PA, urokinase, streptokinase)

Does the patient have:
Known congenital coagulation factor deficiency? ☐ Yes ☐ No
Which factor? _____
Known coagulation factor inhibitor? ☐ Yes ☐ No
(If type of inhibitor is unknown we suggest ordering consult #553)
Specific for Factor? _____

MICROBIOLOGY

Isolated Organism Referred for Identification

All of the following information must be submitted to obtain identification of any organism submitted.

Source: _____
No. of times isolated from different specimens (same patient):
_____
Date of onset: _____ Date collected: _____
Recovery Medium: _____
Transport Medium: _____
Description (gram reaction, morphology tests performed):
_____
Extent of identification requested: _____

Antimicrobial Susceptibility and Assay

Source: _____

Organism Identification: _____
(*If not known, add appropriate ID test*)
Antibiotic to be tested (if applicable): _____
_____

Serum Bacterial Titer (SBT)

Send room temperature slant and frozen serum.
Source: _____ Organism: _____
Antibiotic: _____ Dose/Time: _____
Antibiotic: _____ Dose/Time: _____