MAYO CLINIC
Mayo Medical Laboratories

Tay-Sachs Disease Questionnaire

Instructions: Information requested on this form is necessary for the accurate interpretation of test results. It should be completed by the ordering physician's office personnel and submitted with the specimen or faxed to 507-266-2888.

Ordering Physician Name	Phone	Fax

Patient Background Information

Patient Name – Last Name	First Name	Middle Initial	Birth Date *(Month, DD, YYYY)*

Ethnicity (check all that apply)
☐ Ashkenazi Jewish (Eastern European) ☐ French-Canadian ☐ Other (please specify) _____

Indications for testing (check all that apply)
☐ Routine screening ☐ Family history of Tay-Sachs disease ☐ Suspected diagnosis, clinical history: _____

Gender	If female, is the patient	Is the patient or patient's partner pregnant? ☐ Yes ☐ No
☐ Male ☐ Female	taking oral contraceptives? ☐ Yes ☐ No	If yes, gestational age: _____weeks _____ days

Does the patient have any chronic or current illnesses? ☐ Yes ☐ No
If yes please specify:

Partner Name – Last Name	First Name	Middle Initial	Birth Date *(Month, DD, YYYY)*

Is there any history of Tay-Sachs disease	Has the patient or a family member previously
in the patient or partner's family? ☐ Yes* ☐ No	had testing for Tay-Sachs disease/carrier status? ☐ Yes* ☐ No

*If yes, please indicate: (use additional sheet of paper if more than three individuals)

Relationship	Affected	Carrier	Result	Name (Optional)	Tested at Mayo?
_____	☐	☐	_____	_____	☐ Yes ☐ No
_____	☐	☐	_____	_____	☐ Yes ☐ No
_____	☐	☐	_____	_____	☐ Yes ☐ No

Please contact Mayo Medical Laboratories at 1-800-533-1710 for questions regarding testing or result interpretation.

MML Supply T355

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