

PAX2 CLINICAL TEST REQUEST FORM

You have requested PAX2 gene testing for your patient. In order to provide the most accurate interpretation of your patient's results, we ask that you provide a brief summary of clinical findings and family history.

Patient Name: _____

Ordering Physician: _____

Patient Date of Birth: _____

Genetic Counselor: _____

Medical Record Number: _____

Contact Phone: _____

Mailing address for results

Contact Fax: _____

Clinical information:

Please check any relevant clinical findings, or describe additional clinical findings in the space provided.

- Renal findings:

_____ Renal hypoplasia (unilateral / bilateral)

_____ Vesico-Uretral Reflux

_____ Renal failure

- Eye findings:

_____ Optic nerve Coloboma

_____ Iris Coloboma

_____ Optic disc hypoplasia

_____ Cataracts

_____ Microphthalmia

- Other findings:

_____ Hearing loss

_____ Structural CNS lesion

- Please describe any relevant family history:

Research activities:

We perform research in order to better describe what happens to people who have changes in the PAX2 gene. We do not expect that this research will directly benefit you, but we hope it will allow us to learn more about your condition. In our research, we would not use any information that could be used to identify you (such as your name or birth date).

_____ I authorize the clinical lab at the University of Minnesota to use my information in an anonymous manner to perform research about PAX2.

_____ I do not authorize the clinical lab at the University of Minnesota