



Bruton's Tyrosine Kinase (BTK) Genotype Patient Information Sheet

Instructions: Accurate interpretation and reporting of the genetic results is contingent upon the reason for referral, clinical information, ethnic background, and family history information provided. Supply the information requested below and **send paperwork with the specimen.**

Patient Information

Patient Name <i>(First, Middle, Last)</i>	Birth Date <i>(Month DD, YYYY)</i>	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Referring Physician Name	Phone	Fax	
Other Contact	Phone	Fax	
MML Account Number <i>(If known)</i>			

Clinical History *(Check all that apply)*

Treatment History			
Previous diagnosis of X-linked Agammaglobulinemia (XLA)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Immunoglobulin Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date Started <i>(Month DD, YYYY):</i>		Date Last Received <i>(Month DD, YYYY):</i>	
Pertinent Clinical and Laboratory History			
Hypogammaglobulinemia (low IgG, IgM, IgA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinusitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Common Variable Immunodeficiency (CVID)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsils present?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recurrent infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lymph nodes present?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumonia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Splenomegaly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CD19+ B-cells present in blood (>1%)?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Btk protein by flow cytometry	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Equivocal <input type="checkbox"/> Carrier <input type="checkbox"/> Unknown		
Other diagnosis:			
Other information (such as allogeneic stem cell transplant -indicate type [myeloablative vs non-myeloablative] and date):			
Ethnic Background - <i>Ethnic background may assist with interpretation of test results.</i>			
<input type="checkbox"/> European/Caucasian <i>(List countries of origin)</i> _____			
<input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other <i>(specify)</i> _____			

Family History

Normal	<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)
Recurrent infections	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling(s)
Are other male relatives known to be affected? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate their relationship to the patient:		
Are other female 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 was tested at Mayo Clinic, include the name of the family member:			