

PATIENT HISTORY FOR PRENATAL OR EXPANDED CARRIER SCREENING

Patient Name _____ Date of Birth _____ Sex F M
 Physician _____ Physician Phone _____
 Practice Specialty _____ Physician Fax _____
 Genetic Counselor _____ Counselor Phone _____

Patient's ethnicity (check all that apply)

- African or African-American
- Ashkenazi Jewish
- Asian, East Asian (e.g., Chinese, Japanese)
- Asian, South Asian (e.g., Indian, Pakistani)
- Asian, Southeast Asian (e.g., Filipino, Vietnamese)
- Caucasian, Northern European (e.g., British, German)
- Caucasian, Southern European (e.g., Italian, Greek)
- Caucasian, French Canadian or Cajun
- Caucasian, Finnish
- Caucasian, Mixed
- Hispanic
- Middle Eastern
- Native American
- Pacific Islander
- Other _____

Is the patient/couple pregnant? Y N

Is the patient's partner being tested at the same time? Y N

Reason for testing:

- Carrier screening (no family history)
- Known family history. Describe: _____
- Known carrier or prior testing. Describe: _____
- Other. Describe: _____

Check the carrier screening you intend to order.

- 2014671 Expanded Carrier Screen Genotyping with Fragile X
- 2014674 Expanded Carrier Screen Genotyping
- 2014677 Expanded Carrier Screen by Next Generation Sequencing with Fragile X
- 2014680 Expanded Carrier Screen by next Generation Sequencing

For questions, contact an ARUP genetic counselor at (800) 242-2787, ext. 2141

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