ARUP LABORATORIES

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform expanded carrier screening.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR EXPANDED CARRIER SCREENING

Patient Name _____ Date of Birth_____ /_____/_____Gender [ ] F [ ] M

Physician _____ Physician Phone (_____)_____Practice Specialty_____

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? [ ] Yes [ ] No
Is the patient's partner being tested at the same time? [ ] No [ ] Yes, name_____

Reason for testing:

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

Circle 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

Master Label