ARUP LABORATORIES

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

PATIENT HISTORY FOR PERIODIC FEVER SYNDROMES TESTING

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 American	[ ] Ashkenazi Jewish	[ ] Asian	[ ] Caucasian
[ ] Hispanic	[ ] Middle Eastern	[ ] Native American	[ ] Other_____

Is the patient SYMPTOMATIC? [ ] No [ ] Yes

Please check all symptoms that apply:

[ ] Recurrent fever	[ ] Abdominal pain	[ ] Amyloidosis
[ ] Colchicine treatment responsive	[ ] Deafness	[ ] Developmental delay
[ ] Joint pain/arthritis	[ ] Osteomyelitis	[ ] Peritonitis
[ ] Pleuritis	[ ] Pyoderma gangrenosum	[ ] Skin eruption/inflammation
[ ] Anemia (describe: _____)		[ ] Other _____

Suspected Diagnosis:

[ ] Cyclic Neutropenia	[ ] Familial Mediterranean Fever (FMF)
[ ] Majeed Syndrome	[ ] Hyperimmunoglobulinemia D syndrome (HIDS)
[ ] Muckle-Wells Syndrome	[ ] Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)
[ ] NOMID/CINCA	[ ] Familial Cold Autoinflammatory Syndrome (FCAS)
[ ] Severe Congenital Neutropenia	[ ] Other _____

Lab Results:

Absolute neutrophil count	[ ] Normal	[ ] Abnormal	[ ] Not performed	[ ] Unknown
Erythrocyte sedimentation rate (ESR)	[ ] Normal	[ ] Abnormal	[ ] Not performed	[ ] Unknown
Leukocytosis (WBC)	[ ] Normal	[ ] Abnormal	[ ] Not performed	[ ] Unknown
Fibrinogen serum concentration	[ ] Normal	[ ] Abnormal	[ ] Not performed	[ ] Unknown

Does the patient have a FAMILY HISTORY of a periodic fever syndrome? [ ] No [ ] Yes [ ] Unknown
NAME OF THE DISORDER diagnosed in the symptomatic/affected relative(s): _____
RELATIONSHIP of the affected family member(s) to the patient: _____
Is the relative a [ ] healthy carrier [ ] affected with the above disorder
What are the mutations identified in the relative? _____

A copy of the DNA test results for the affected/carrier relative MUST be provided.

Circle the test you intend to order.

2007370 Periodic Fever Syndromes Panel, Sequencing, 7 Genes, and Deletion/Duplication, 6 Genes: Next generation sequencing for 7 genes (*MEFV, TNFRSF1A, MVK, NLRP3, ELANE, PSTPIP1*, and *LPIN2*) and array analysis for 6 genes (*MEFV, TNFRSF1A, MVK, NLRP3, PSTPIP1* and *LPIN2*) known to cause periodic fever syndromes.

2002658 Familial Mediterranean Fever (MEFV) Sequencing - Sequencing of the entire MEFV coding region and intron/exon boundaries; clinical sensitivity is approximately 80%.

2001961 Familial Mutation, Targeted Sequencing: Targeted sequencing for a variant previously identified in a family member; copy of relative's lab result is REQUIRED. Contact an ARUP genetic counselor prior to ordering.

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

Master Label