ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY
A nonprofit enterprise of the University of Utah and its Department of Pathology

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THIS IS NOT A TEST REQUEST FORM.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR BIOCHEMICAL GENETIC TESTING

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-American ☐ Asian ☐ Hispanic ☐ Native American

☐ Ashkenazi Jewish ☐ Caucasian ☐ Middle Eastern ☐ Other: ______________________

Clinical Diagnosis / Reason for Referral:______________________

____

Does the patient have symptoms? ☐ No ☐ Yes (check all that apply)

☐ Acidosis ☐ Hypoglycemia

☐ Cardiomyopathy ☐ Macrocephaly

☐ Coarse features ☐ Microcephaly

☐ Corneal clouding ☐ Organomegaly

☐ Developmental Delay ☐ Seizures

☐ Failure to thrive ☐ Skeletal anomalies

☐ Hyperammonemia ☐ Other symptom(s): ______________________

List the patient's medications, including antibiotics, anticonvulsants, and enzyme replacement therapy: ______________________

____

____

List the patient's specific diet or formula: ______________________

____

____

Are the patient's parents related to one another? ☐ No ☐ Yes ☐ Unknown

If yes, describe: ______________________

Comments or special instructions: ______________________

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Please submit this form with the sample or fax this form to
ARUP Biochemical Genetics Laboratory at (801) 584-5249

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

Master Label