

**PATIENT HISTORY FOR COBALAMIN/PROPIONATE/HOMOCYSTEINE  
RELATED DISORDERS GENE PANEL**

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  Ashkenazi Jewish  Asian  Caucasian  
 Hispanic  Middle Eastern  Native American  Other \_\_\_\_\_

**Clinical Diagnosis /Reason for Referral:**

- Methylmalonic aciduria  Homocystinuria  Propionic acidemia  Other \_\_\_\_\_

**Patient's Symptoms:** Check all that apply.

- Failure to thrive  Craniofacial \_\_\_\_\_  Renal \_\_\_\_\_  
 Neurological \_\_\_\_\_  Gastrointestinal \_\_\_\_\_  Cutaneous \_\_\_\_\_  
 Neuromuscular \_\_\_\_\_  Hematologic \_\_\_\_\_  Respiratory \_\_\_\_\_  
 Skeletal \_\_\_\_\_  Immunologic \_\_\_\_\_  Other \_\_\_\_\_  
 Cardiovascular \_\_\_\_\_  Ocular \_\_\_\_\_

**Laboratory Findings**

- \*Vitamin B12**  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
**\*Methylmalonic acid before vitamin B12 therapy**  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
**\*Methylmalonic acid after vitamin B12 therapy**  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
**Homocysteine, Total**  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
**Plasma Acylcarnitine Profile**  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
**Plasma Amino Acids**  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
**Urine Organic Acids**  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
**Acidosis**   
**Hypoglycemia**

**\*If the patient is a breast fed baby, was MATERNAL vitamin B12 deficiency excluded?** \_\_\_\_\_

**Has the patient undergone previous DNA testing?**  No  Yes  Unknown  
 If yes, please describe the gene/disorder, methodology, and results \_\_\_\_\_

**Family history of cobalamin/propionate/homocysteine metabolism related disorder?**  No  Yes  Unknown  
 If yes, specify the affected relative's relationship to the patient, symptoms/clinical diagnosis, and age of onset. \_\_\_\_\_

**Has DNA testing been performed for these family members?**  No  Yes  Unknown  
 Attach a copy of the relative's DNA laboratory result. **REQUIRED for familial mutation testing.**

**Circle the test you intend to order:**

**Initial Test for Cobalamin/Propionate/Homocysteine Metabolism Related Disorder**  
 2011157 Cobalamin/Propionate/Homocysteine Related Disorders Panel, Sequencing (25 Genes) and Deletion/Duplication (24 Genes)

**Follow-up testing for family members. A copy of a relative's DNA laboratory result is REQUIRED**  
 2001961 Familial Mutation, Targeted Sequencing: Tests for a specific sequence change previously identified in a family member.

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

