ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

A nonprofit enterprise of the University of Utah and its Department of Pathology

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PATIENT HISTORY FOR MOLECULAR GENETIC TESTING

Client Number _____

Patient Name _____ Date of Birth _____ Sex ☐ F ☐ M

Physician Name _____ Physician Phone _____

Practice Specialty _____ Physician Fax _____

Genetic Counselor _____ Counselor Phone _____

Comments or Special Instructions _____

_____

_____

Reason for testing (check all that apply):

☐ Asymptomatic

☐ Carrier testing

☐ Diagnostic testing

☐ Presymptomatic

☐ Symptomatic

☐ Other (describe) _____

If the patient is symptomatic, list all manifestations: _____

_____

_____

Has anyone in the patient's family had DNA testing for this disorder?

☐ No ☐ Yes: Laboratory used: _____

Laboratory result: _____

(Include a copy of the laboratory report)

Please include a multi-generational pedigree with disorder symptoms noted.

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

Master Label