ARUP LABORATORIES

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

PATIENT HISTORY FOR PRIMARY ANTIBODY DEFICIENCY GENETIC 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_____

CLINICAL DIAGNOSIS/Reason for referral:

[ ] Agammaglobulinemia [ ] Hyper IgM syndrome [ ] Combined immunodeficiency
[ ] IgA deficiency [ ] Common variable immunodeficiency [ ] Other_____

SYMPTOMS? [ ] No [ ] Yes, check all that apply

[ ] Respiratory infections [ ] Histoplasmosis [ ] Cytopenia [ ] Skin infections
[ ] Gastrointestinal disease [ ] Cryptococcosis [ ] Granulomatous disease [ ] Malignancy, please specify _____
[ ] Oral ulcers [ ] Stomatitis [ ] Autoimmune conditions _____
[ ] Gingivitis [ ] Failure to thrive [ ] Empyema [ ] Other _____
[ ] Otitis media [ ] Lymphadenopathy [ ] Meningitis _____
[ ] Candidiasis [ ] Neutropenia [ ] Sepsis

LABORATORY FINDINGS

Total White Blood (cells/ul)	[ ] Normal	[ ] Abnormal (result: _____)	[ ] Not performed	[ ] Unknown
Lymphocytes (cells/ul)	[ ] Normal	[ ] Abnormal (result: _____)	[ ] Not performed	[ ] Unknown
Granulocytes (cells/ul)	[ ] Normal	[ ] Abnormal (result: _____)	[ ] Not performed	[ ] Unknown
Monocytes (cells/ul)	[ ] Normal	[ ] Abnormal (result: _____)	[ ] Not performed	[ ] Unknown
CD3 (cells/ul)	[ ] Normal	[ ] Abnormal (result: _____)	[ ] Not performed	[ ] Unknown
CD4 (cells/ul)	[ ] Normal	[ ] Abnormal (result: _____)	[ ] Not performed	[ ] Unknown
CD45RA (cells/ul)	[ ] Normal	[ ] Abnormal (result: _____)	[ ] Not performed	[ ] Unknown
CD45RO (cells/ul)	[ ] Normal	[ ] Abnormal (result: _____)	[ ] Not performed	[ ] Unknown
CD8 (cells/ul)	[ ] Normal	[ ] Abnormal (result: _____)	[ ] Not performed	[ ] Unknown
CD19 (cells/ul)	[ ] Normal	[ ] Abnormal (result :_____)	[ ] Not Performed	[ ] Unknown
B (cells/ul)	[ ] Normal	[ ] Abnormal (result: _____)	[ ] Not performed	[ ] Unknown
Memory B (cells/ul)	[ ] Normal	[ ] Abnormal (result: _____)	[ ] Not performed	[ ] Unknown
NK (cells/ul)	[ ] Normal	[ ] Abnormal (result: _____)	[ ] Not performed	[ ] Unknown
IgE serum levels	[ ] Normal	[ ] Abnormal (result: _____)	[ ] Not performed	[ ] Unknown
IgG/A/M serum levels	[ ] Normal	[ ] Abnormal (result: _____)	[ ] Not performed	[ ] Unknown
Lymphocyte response to mitogens	[ ] Normal	[ ] Abnormal (result: _____)	[ ] Not performed	[ ] Unknown

Has the patient had an allogeneic bone marrow or umbilical cord blood transplant? [ ] No [ ] Yes [ ] Unknown
Is the patient on immunoglobulin replacement therapy? [ ] No [ ] Yes [ ] Unknown
Has the patient undergone previous DNA testing? [ ] No [ ] Yes [ ] Unknown
If yes, please describe the gene/disorder, methodology, and results_____

FAMILY HISTORY of primary antibody deficiency? [ ] No [ ] Yes [ ] Unknown
If yes, attach a PEDIGREE or specify the relative's relationship to the patient, symptoms/clinical diagnosis and age of onset.
_____
Has DNA testing been performed for these family member(s)? [ ] 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 Primary Antibody Deficiency	
2011156	Primary Antibody Deficiency Panel, Sequencing (35 Genes) and Deletion/Duplication (26 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 a genetic counselor at (800) 242-2787, ext. 2141

Master Label