ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

THIS IS NOT A TEST REQUEST FORM.

The information below is required to perform genetic testing for congenital adrenal hyperplasia. Please complete this form and submit it with the test request form or electronic packing list.

CAH (21-Hydroxylase Deficiency) Common Mutations

Please complete the following:

Patient _____ Accession # _____ Date of birth _____

Date drawn _____ Ethnic background _____

Indication for test:

❑ Positive newborn screen

❑ Patient affected with:

- ❑ Classic congenital adrenal hyperplasia (CAH)
  - ❑ Salt-wasting ❑ Non-salt-wasting
- ❑ Non-classic CAH
- ❑ Ambiguous genitalia
- ❑ Hirsutism
- ❑ Polycystic ovarian syndrome
- ❑ Other:_____

If affected, please provide biochemical test results, if performed:

Serum 17-OHP:_____

Plasma renin activity (PRA):_____

Stimulated ACTH:_____

Other (androstenedione, testosterone):_____

❑ Patient has a positive family history of the following:

_____

(Please detail affected individual's relationship to patient.)

❑ Known familial mutation:_____

(Please indicate name of mutation(s); e.g., V281L)

❑ Patient is having carrier screening because partner is a known carrier of CAH.
