ARUP LABORATORIES

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

PATIENT HISTORY FOR FAMILY SPECIFIC MUTATION TESTING

Patient Name _____ Date of Birth_____ /_____/_____ Gender [ ] F [ ] M

Physician _____ Physician Phone (_____)_____Practice Specialty_____

Genetic Counselor _____ Counselor Phone (_____)_____

Disease/Gene for which the patient is seeking testing: _____
Does the patient have SYMPTOMS?
[ ] No [ ] Yes, please list all symptoms_____

Sample Type

[ ] Blood	[ ] Amniotic Fluid*	[ ] Direct Chorionic Villi**
[ ] DNA	[ ] Cultured Amniocytes	[ ] Cultured Chorionic Villi

* A backup culture is highly recommended for all direct amniocentesis/CVS samples.
Do you need ARUP to start a backup culture? [ ] No [ ] Yes (If yes, order ARUP test code 0040182)
Will a backup culture be maintained at another lab? [ ] No [ ] Yes Lab Name_____

** Would you like direct testing performed on uncultured chorionic villi or amniotic fluid? [ ] Yes [ ] No
(Some tests have not been validated on CVS samples; please contact a genetic counselor (800) 242-2787 x2141 to discuss testing options. Also, if a result is not possible, there will be an additional charge for testing cultured cells.)

To perform familial mutation testing, a copy of a relative's laboratory report documenting the gene and specific mutation(s) MUST accompany this order for HIPAA compliance.

[ ] An affected relative's laboratory report will accompany this sample.

If the relative's DNA testing was NOT performed at ARUP, submission of a positive control sample from an affected relative is highly recommended. Control samples are tested at no cost and are used to confirm the patient's test results; test results are NOT issued to controls.

[ ] **No control is being submitted** as the affected relative was tested at ARUP labs.
Relative's name: _____DOB: _____ Relationship to the patient:_____

[ ] **A sample from the affected relative will accompany the patient's sample**. (Collect 3mL of whole blood from affected relative in a lavender top (EDTA) tube and ship refrigerated. Label specimen with relative's name and birthdate and place a separate order for Sequencing Control, ARUP test code 0051610).
Relative's name: _____ DOB: _____ Relationship to the patient:_____

[ ] **The affected relative has been contacted and has agreed to provide a sample.** We would like ARUP to send a collection kit to the affected relative, free of charge.
Relative's name: _____ DOB: _____ Relationship to the patient:_____
Relative's address: _____
Relative's phone number (Required for FedEx): _____

[ ] **Please run this patient's test WITHOUT a sample from the affected relative**.

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

Master Label