ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

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

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THIS IS NOT A TEST REQUEST FORM.
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 _____ Sex ☐ F ☐ M

Physician _____ Physician Phone _____

Practice Specialty _____ Physician Fax _____

Genetic Counselor _____ Counselor Phone _____

Disease/gene for which the patient is seeking testing: _____

Does the patient have symptoms? ☐ No ☐ Yes

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?** ☐ No ☐ Yes
(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.)

☐ **An affected relative's laboratory report will accompany this sample.** To perform a 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.

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