ARUP LABORATORIES

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

PATIENT HISTORY FOR HOLOPROSENCEPHALY NONSYNDROMIC GENE 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 _____

Has the patient/ pregnancy been diagnosed with a type of holoprosencephaly? [ ] No [ ] Yes
If yes, check one of the following:
[ ] Alobar [ ] Semilobar [ ] Lobar [ ] Middle interhemispheric variant [ ] Microform [ ] Other _____

Other findings?
[ ] Microcephaly [ ] Single central incisor [ ] Short stature/failure to thrive [ ] Laterality defect
[ ] Craniofacial (describe) _____
[ ] Neurological (describe)_____
[ ] Cardiac defect (describe)_____
[ ] Urogenital anomalies (describe) _____
[ ] Endocrine issues (describe)_____
[ ] Gastrointestinal anomalies (describe) _____
[ ] Ectro-/Polydactaly (describe) _____
[ ] Other _____

Previous testing for holoprosencephaly? [ ] No [ ] Yes

If yes, describe, Chromosome analysis [ ] No [ ] Yes [ ] Result_____
Genomic microarray [ ] No [ ] Yes [ ] Result_____
Molecular genetic test describe)_____
Other _____

FAMILY HISTORY of holoprosencephaly or any variants thereof? [ ] No [ ] Yes [ ] Unknown
If yes, specify the RELATIONSHIP of the family member(s) to the patient and detail the symptoms in each.

_____

Please attach PEDIGREE if possible.

Circle the Holoprosencephaly test you intend to order.

2008848 Holoprosencephaly Panel, Nonsyndromic, Sequencing and Deletion/Duplication, 11 Genes. May be used for prenatal or postnatal testing. If ordering on a fetal sample, please also order maternal cell contamination analysis separately (test code 0050608).

2001961 Familial Mutation, Targeted Sequencing. Tests for a variant previously identified in a family member. A copy of relative's DNA laboratory result is REQUIRED. Contact an ARUP genetic counselor prior to ordering.

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

Master Label