ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

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

500 Chipeta Way
Salt Lake City, Utah 84108-1221
phone: (801) 583-2787 | toll free: (800) 242-2787
fax: (801) 583-2712 | www.aruplab.com

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

PATIENT HISTORY FOR AUTISM AND INTELLECTUAL DISABILITY

Patient's Name _____ **Date of Birth** ___/___/___ **Gender** ☐ **Female** ☐ **Male**

Physician _____ **Physician Phone** (___)_____ **Physician 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 Findings (check all that apply):

Growth
☐ Failure to thrive
☐ Overgrowth
☐ Short stature

Development
☐ Fine motor delay
☐ Gross motor delay
☐ Speech delay

Cognition/behavior
☐ Autism spectrum disorder
☐ Learning disability
☐ Intellectual disability; IQ/DQ:_____
☐ Oppositional defiant disorder
☐ Obsessive compulsive disorder
☐ Pervasive developmental delay

Neurologic
☐ Ataxia/dystonia/chorea
☐ Hypotonia
☐ Seizures
☐ Spasticity
☐ Structural brain abnormality

Cardiac
☐ Cardiomyopathy
☐ Structural heart defect
(Describe: _____)

Musculoskeletal
☐ Scoliosis
☐ Vertebral anomaly
☐ Limb anomaly
☐ Organomegaly

Craniofacial
☐ Dysmorphic facial features
☐ Cleft lip +/- cleft palate
☐ Craniosynostosis
☐ Macrocephaly
☐ Microcephaly
☐ Corneal clouding

Biochemical
☐ Acidosis
☐ Hypoglycemia
☐ Hyperammonemia

Genitourinary
☐ Ambiguous genitalia
☐ Hydronephrosis
☐ Undescended testes

List patient's medications and, if applicable, describe modified diet. Include formulas, vitamins, supplements, antibiotics, anticonvulsants, or enzyme replacement therapy: _____

_____

Does the patient have a FAMILY HISTORY of autism or a related genetic disorder? ☐ No ☐ Yes ☐ Unknown
If yes, attach a pedigree or specify the relatives' diagnoses, ages of onset, and relationships to the patient. _____

_____

Has DNA testing been performed for these family member(s)? ☐ No ☐ Yes ☐ Unknown
Has the patient undergone previous DNA testing for autism? ☐ No ☐ Yes ☐ Unknown

If yes to either of the above, please describe test(s) and results: _____

Check the test that you intend to order:

Primary panel for Autism/Intellectual Disability:

☐ 2014314 Autism and Intellectual Disability Comprehensive Panel

Individual components available separately:

☐ 2003414 Cytogenomic SNP Microarray
☐ 2009033 Fragile X (*FMR1*) with Reflex to Methylation Analysis
☐ 2014312 Autism and Intellectual Disability Metabolic Panel

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

Master Label

In cooperation with the National Institutes of Health's efforts to improve the understanding of specific genetic changes, ARUP Laboratories submits HIPAA-compliant, de-identified (cannot be traced back to the patient) genetic test results and health information to public databases. Confidentiality of each sample is maintained. You may choose not to share your test result by calling ARUP at (800) 522-2787, ext. 3301. Your de-identified test information will not be shared with public databases after the request is made, but a separate opt-out request is required for each genetic test. For more information, please visit www.aruplab.com/genetics.