ARUP LABORATORIES

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 Name _____ **Date of Birth**____ /_____/_____ **Sex [ ] 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 _____

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, intellectual disability or a related 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 or intellectual disability? [ ] No [ ] Yes [ ] Unknown

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

Are the patient's parents related to one another? [ ] No [ ] Yes [ ] Unknown

If yes, please describe_____

Circle the test that you intend to order:

Primary panel for Autism/Intellectual Disability:
2014314 Autism and Intellectual Disability Comprehensive Panel
Individual components are available separately:
2003414 Cytogenomic SNP Microarray
2009033 Fragile X (FMR1) with Reflex to Methylation Analysis
2014312 Autism and Intellectual Disability Metabolic Panel

Master Label

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