ARUP LABORATORIES

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

500 Chipeta Way
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THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

CRITICALLY ILL RAPID GENETIC DIAGNOSIS PANEL PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

Sex Assigned at Birth: ☐Female ☐Male ☐Intersex **Gender Identity (optional):** ☐Female ☐Male ☐_____

Physician: _____ **Physician's Phone:** _____

Practice Specialty: _____ **Physician's Fax:** _____

Genetic Counselor: _____ **Counselor's Phone:** _____

Patient's Ethnicity/Ancestry (check all that apply)

☐ African American/Black ☐ Asian ☐ Hispanic ☐ White ☐ Other: _____

List country of origin (if known): _____

What is the patient's suspected clinical diagnosis/indication for testing? _____

List specific genes of interest: _____

Describe ALL findings:

☐ Prenatal Findings: _____

☐ Decreased fetal movement ☐ Polyhydramnios

☐ Prematurity; list gestational age at delivery: _____

☐ Growth: _____

☐ Failure to thrive ☐ IUGR ☐ Macrocephaly ☐ Microcephaly ☐ Overgrowth

☐ Body wall defect: _____

☐ Cancer/tumor: _____

☐ Cardiac: _____

☐ Arrhythmia ☐ Bradycardia

☐ CNS (structural brain malformations): _____

☐ Craniofacial: _____

☐ Dermatologic: _____

☐ Dysmorphic features: _____

☐ Gastrointestinal: _____

☐ Genital: _____

☐ Hematologic: _____

☐ Immunologic: _____

☐ Limb abnormalities: _____

☐ Metabolic: _____

☐ Acidosis ☐ Hyperammonemia ☐ Liver function defect

☐ Muscular: _____

☐ Neurologic: _____

☐ Abnormal movements ☐ Ataxia ☐ Central apnea
☐ Cranial nerve defects ☐ Hypotonia ☐ Hypertonia/spasticity ☐ Seizures

☐ Ophthalmologic: _____

☐ Otologic: _____

☐ Pulmonary: _____

CRITICALLY ILL RAPID GENETIC DIAGNOSIS PANEL PATIENT HISTORY FORM

☐ Diaphragmatic defect ☐ Laryngotracheal abnormalities ☐ Lung malformation ☐ Respiratory failure

☐ Skeletal:_____

☐ Hyperextensibility ☐ Joint contractures ☐ Vertebral anomalies/scoliosis

☐ Urinary tract:_____

☐ Other:_____

Has the patient undergone previous genetic testing? ..... ☐ No ☐ Yes

☐ Chromosome analysis ..... ☐ Normal ☐ Abnormal

☐ Genomic microarray ..... ☐ Normal ☐ Abnormal

Other:_____ Method:_____ ☐ Normal ☐ Abnormal

Other:_____ Method:_____ ☐ Normal ☐ Abnormal

Other:_____ Method:_____ ☐ Normal ☐ Abnormal

Other:_____ Method:_____ ☐ Normal ☐ Abnormal

If any test results were equivocal or abnormal, please describe:_____

Has the patient had an MRI? ..... ☐ No ☐ Yes ☐ Unknown

If yes, was it abnormal? ..... ☐ No ☐ Yes ☐ Unknown

If abnormal, describe:_____

Mother's Sample

Date of sample collection: ..... ☐ Not Available ☐ Will be sent later

Biological mother's name:_____ DOB:_____

Symptoms? ☐ No ☐ Yes, describe: _____

Father's Sample

Date of sample collection: ..... ☐ Not Available ☐ Will be sent later

Biological father's name:_____ DOB:_____

Symptoms? ☐ No ☐ Yes, describe: _____

Please ATTACH the following:

1. Completed consent form for patient
2. Clinical summary report
3. Three generation medical PEDIGREE detailing all diagnoses/symptoms and age of onset in each relative
4. Genomic microarray results showing copy number changes that are pathogenic or have unknown significance
5. Any genetic test results that identified pathogenic mutations or variants of unknown significance
6. Any abnormal MRI results
7. Any abnormal Echo/Ultrasound/X-ray or metabolic test results

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

Master Label

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