ARUP LABORATORIES

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

PATIENT HISTORY FOR INHERITED INSULIN RESISTANCE SYNDROMES (*INSR*) 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_______________________

Are there SYMPTOMS OF AN INSULIN RESISTANCE SYNDROME? [ ] No [ ] Yes [ ] Unknown

If yes, check all that apply:

[ ] Intrauterine growth restriction
[ ] Failure to thrive
[ ] Dysmorphic features
[ ] Thick skin
[ ] Lack of subcutaneous fat
[ ] Other ___________________
[ ] Distended abdomen
[ ] Premature/dysplastic teeth
[ ] Gingival hyperplasia
[ ] Enlarged genitalia
[ ] Cystic ovaries
[ ] Pineal hyperplasia
[ ] Hirsutism
[ ] Acanthosis nigricans
[ ] Amenorrhea
[ ] Diabetes mellitus

LABORATORY FINDINGS

Glucose (fasting)	[ ] Normal	[ ] Low (result: ____)	[ ] High (result: ____)	[ ] Not performed	[ ] Unknown
Glucose (post prandial)	[ ] Normal	[ ] Low (result: ____)	[ ] High (result: ____)	[ ] Not performed	[ ] Unknown
Insulin	[ ] Normal	[ ] Low (result: ____)	[ ] High (result: ____)	[ ] Not performed	[ ] Unknown
Hyperandrogenism	[ ] No	[ ] Yes (Describe: _________________________________)			
Insulin binding (fibroblasts)	[ ] Normal	[ ] Abnormal (% binding: _____________)		[ ] Not performed	[ ] Unknown

Is there a FAMILY HISTORY OF ANY OF THE ABOVE SYMPTOMS? [ ] No [ ] Yes [ ] Unknown
If yes, please specify the RELATIONSHIP of the family member(s) to the patient and describe the symptoms in each symptomatic relative.
____

Has DNA testing for the *INSR* gene been performed for these family member(s)? [ ] No [ ] Yes [ ] Unknown
If yes, please attach a copy of the laboratory result (REQUIRED for familial mutation testing)

DESCRIPTION OF INHERITED INSULIN RESISTANCE SYNDROME TESTING

2006274 Inherited Insulin Resistance Syndromes (*INSR*) Sequencing: Sequencing of the *INSR* coding regions and intron/exon boundaries. Clinical sensitivity predicted to be greater than 90% in individuals with a clinical diagnosis of Donohue syndrome (Leprechaunism), Rabson-Mendenhall syndrome, and Type A insulin resistance.

2001961 Familial Mutation, Targeted Sequencing: Targeted sequencing for an *INSR* mutation previously identified in a family member.

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

Master Label