ARUP LABORATORIES

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

PATIENT HISTORY FOR CHRONIC GRANULOMATOUS DISEASE (CGD) 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_____

Does the patient have SYMPTOMS of CGD? [ ] No [ ] Yes, check all that apply
Age at first presentation: _____

[ ] Recurrent infection [ ] Nausea/ vomiting [ ] Gastric obstruction
[ ] Pneumonia [ ] Diarrhea [ ] Bone infection
[ ] Lymphadenitis [ ] Colitis [ ] Poor wound healing
[ ] Skin abscess [ ] Urinary stricture/ obstruction [ ] Other_____
[ ] Visceral abscess (location :_____)

Has FUNCTIONAL TESTING (neutrophil oxidative burst assay; DHR) been performed? [ ] No [ ] Yes [ ] Unknown
If yes, what was result? [ ] Abnormal [ ] Normal [ ] Unknown

RADIOLOGICAL FINDINGS

Bone scan [ ] Abnormal [ ] Normal [ ] Not performed
Chest x-ray [ ] Abnormal [ ] Normal [ ] Not performed

Does the patient have a FAMILY HISTORY of CGD? [ ] No [ ] Yes [ ] Unknown
If yes, attach a PEDIGREE or specify the RELATIONSHIP of the family member(s) to the patient and detail the symptoms/age of onset in each symptomatic relative.

_____

What is the disease severity in affected males in the family? [ ] Severe [ ] Mild [ ] Unknown
Was DNA testing performed for these family members? [ ] Yes [ ] No [ ] Unknown
If yes, please attach a copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing).

Has the patient undergone previous DNA testing for CGD? [ ] No [ ] Yes
If yes, please describe test(s) and results_____

Circle the CGD test you intend to order.

2006356 Chronic Granulomatous Disease (*CYBB* Gene Scanning and *NCF1* Exon 2 GT Deletion) with Reflex to *CYBB* Sequencing
Gene scanning of the *CYBB* coding region and intron/exon boundaries with identified variants confirmed by sequencing. Targeted testing for the common GT deletion in exon 2 of *NCF1*. Clinical sensitivity is 86% for CGD.

2006361 Chronic Granulomatous Disease, X-Linked (*CYBB*) Gene Scanning with Reflex to Sequencing
Gene scanning of the *CYBB* coding region and intron/exon boundaries with identified variants confirmed by sequencing. Clinical sensitivity is 68% for CGD.

2006366 Chronic Granulomatous Disease (*NCF1*) Exon 2 GT Deletion
Targeted testing for the common GT deletion in exon 2 of *NCF1* associated with autosomal recessive CGD. Clinical sensitivity is 18% for CGD.

2001961 Familial Mutation, Targeted Sequencing
Tests for a *CYBB* sequence change previously identified in a family member. A copy of an affected relative's DNA laboratory result is REQUIRED.

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

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