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

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

PATIENT HISTORY FOR MOLECULAR GENETIC TESTING

Patient Name: ______________________ **Date of Birth:** ____________ **Sex:** ☐ Female ☐ Male
Ordering Provider: ______________________ **Provider's Phone:** ______________________
Practice Specialty: ______________________ **Provider's Fax:** ______________________
Genetic Counselor: ______________________ **Counselor 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 suspected disorder in the patient? ______________________

What test are you ordering at ARUP? ______________________

Reason for testing (check all that apply):

- ☐ Asymptomatic
- ☐ Carrier testing
- ☐ Diagnostic testing
- ☐ Pre-symptomatic
- ☐ Symptomatic
- ☐ Other (describe): ______________________

If the patient is symptomatic, list all manifestations: ______________________

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Has anyone in the patient's family had DNA testing for this disorder?
☐ No ☐ Yes Laboratory used: ______________________
Laboratory result: ______________________
(Include a copy of the laboratory report)

Please include a multi-generational pedigree with disorder symptoms noted.

Master Label

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