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

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## DELETION/DUPLICATION ANALYSIS BY MLPA PATIENT HISTORY FORM

Deletion/duplication analysis by MLPA is only available for the following genes: *F8, MLH1, MSH2, MSH6, SDHB, SDHC, SDHD, SHOX*

Gene(s) for which deletion/duplication analysis is requested: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex Assigned at Birth:  Female  Male  Intersex Gender Identity (optional):  Female  Male  \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider's Phone: \_\_\_\_\_

Practice Specialty: \_\_\_\_\_ Provider'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): \_\_\_\_\_

Reasons for Testing (Check all that apply)

The patient is symptomatic  
(describe) \_\_\_\_\_

The patient had previous uninformative testing for this condition  
(describe) \_\_\_\_\_

There is a known large deletion/duplication in a family member  
(describe) \_\_\_\_\_

**If testing is due to a known deletion/duplication in a family member, submission of the relative's lab result is required.**

Relative's name: \_\_\_\_\_

DOB: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_



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

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