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.

PRENATAL OR EXPANDED CARRIER SCREENING PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ Female ☐ Male

Ordering Provider: _____ **Provider's Phone:** _____

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

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

Patient's ethnicity (check all that apply)

☐ African or African American
☐ Ashkenazi Jewish
☐ Asian, East Asian (e.g., Chinese, Japanese)
☐ Asian, South Asian (e.g., Indian, Pakistani)
☐ Asian, Southeast Asian (e.g., Filipino, Vietnamese)
☐ White, Northern European (e.g., British, German)
☐ White, Southern European (e.g., Italian, Greek)
☐ White, French Canadian or Cajun
☐ White, Finnish
☐ White, mixed ethnicity
☐ Hispanic
☐ Middle Eastern
☐ Native American
☐ Pacific Islander
☐ Other_____

Is the patient/couple pregnant?..... ☐ No ☐ Yes

Is the patient's partner being tested at the same time? ..... ☐ No ☐ Yes

Reason for testing:

☐ Carrier screening (no family history)

☐ Known family history. Describe:_____

☐ Known carrier or prior testing. Describe:_____

☐ Other. Describe:_____

Check the test you intend to order.

☐ **2014677 Expanded Carrier Screen by Next Generation Sequencing with Fragile X**

☐ **2014680 Expanded Carrier Screen by Next Generation Sequencing**

Master Label

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