

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

PERIODIC FEVER SYNDROMES TESTING PATIENT HISTORY FORM

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 or Latino White Other: _____

List country of origin (if known): _____

Suspected Diagnosis (select all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Blau syndrome/pediatric granulomatous arthritis | <input type="checkbox"/> Neonatal onset multisystem inflammatory disease (NOMID)/chronic infantile neurological cutaneous and articular syndrome (CINCA) |
| <input type="checkbox"/> Cyclic neutropenia | <input type="checkbox"/> Severe congenital neutropenia |
| <input type="checkbox"/> Familial cold autoinflammatory syndrome (FCAS) | <input type="checkbox"/> Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS) |
| <input type="checkbox"/> Familial Mediterranean fever (FMF) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hyperimmunoglobulinemia D syndrome (HIDS) | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Majeed syndrome | |
| <input type="checkbox"/> Muckle-Wells syndrome | |

Does the patient have symptoms?..... No Yes (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Pyoderma gangrenosum |
| <input type="checkbox"/> Amyloidosis | <input type="checkbox"/> Joint pain/arthritis | <input type="checkbox"/> Recurrent fever |
| <input type="checkbox"/> Chronic/severe infections | <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> Skin eruption/inflammation |
| <input type="checkbox"/> Colchicine treatment responsive | <input type="checkbox"/> Peritonitis | <input type="checkbox"/> Anemia (describe: _____) |
| <input type="checkbox"/> Contractures | <input type="checkbox"/> Pleuritis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Developmental delay | | |

Lab Results:

- | | | | | |
|--|---------------------------------|-----------------------------------|--|----------------------------------|
| Absolute neutrophil count..... | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Not performed | <input type="checkbox"/> Unknown |
| Erythrocyte sedimentation rate (ESR) | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Not performed | <input type="checkbox"/> Unknown |
| Leukocytes (WBC)..... | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Not performed | <input type="checkbox"/> Unknown |
| Fibrinogen serum concentration..... | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Not performed | <input type="checkbox"/> Unknown |

Is there any relevant family history?..... No Yes Unknown

If yes, attach a pedigree or specify the relative's relationship to the patient. List their symptoms and age of onset:

Has DNA testing been performed for the family member(s)? No Yes Unknown

If yes, indicate: The relative is a healthy carrier affected with the disorder

Please attach a copy of the relative's DNA laboratory result (REQUIRED for familial variant testing).

Indicate the name of the disorder diagnosed and the variants identified: _____

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

