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.

PERIODIC FEVER SYNDROMES TESTING 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/Ancestry (check all that apply)

☐ African American/Black ☐ Asian ☐ Hispanic ☐ White ☐ Other: _____

List country of origin (if known): _____

Suspected Diagnosis (select all that apply):

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

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

☐ Abdominal pain
☐ Amyloidosis
☐ Chronic/severe infections
☐ Colchicine treatment responsive
☐ Contractures
☐ Developmental delay
☐ Hearing loss
☐ Joint pain/arthritis
☐ Osteomyelitis
☐ Peritonitis
☐ Pleuritis
☐ Pyoderma gangrenosum
☐ Recurrent fever
☐ Skin eruption/inflammation
☐ Anemia (describe: _____)
☐ Other: _____

Lab Results:

Absolute neutrophil count	☐ Normal	☐ Abnormal	☐ Not performed	☐ Unknown
Erythrocyte sedimentation rate (ESR)	☐ Normal	☐ Abnormal	☐ Not performed	☐ Unknown
Leukocytosis (WBC)	☐ Normal	☐ Abnormal	☐ Not performed	☐ Unknown
Fibrinogen serum concentration	☐ Normal	☐ Abnormal	☐ Not performed	☐ 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 mutation testing).

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

_____

Check the test you intend to order.

☐ **2007370 Periodic Fever Syndromes Panel, Sequencing and Deletion/Duplication:** Next generation sequencing for genes known to cause periodic fever syndromes.

☐ **2001961 Familial Mutation, Targeted Sequencing:** Tests for a sequence variant previously identified in a family member; a copy of a relative's lab result is REQUIRED

Master Label

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