ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

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

500 Chipeta Way
Salt Lake City, Utah 84108-1221
phone: 801-583-2787 | toll free: 800-242-2787
fax: 801-584-5249 | aruplab.com

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

PATIENT HISTORY FOR BIOCHEMICAL GENETIC TESTING

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

Physician: _____ **Physician Phone:** _____

Practice Specialty: _____ **Physician Fax:** _____

Genetic Counselor: _____ **Counselor Phone:** _____

Patient's Ethnicity (check all that apply)

☐ African-American ☐ Asian ☐ Hispanic ☐ Native American
☐ Ashkenazi Jewish ☐ Caucasian ☐ Middle Eastern ☐ Other: _____

Clinical Diagnosis / Reason for Referral: _____

_____

Newborn Screening Results: ..... ☐ Abnormal ☐ Normal ☐ N/A

Describe any abnormal results: _____

_____

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

☐ Acidosis ☐ Failure to thrive ☐ Organomegaly
☐ Cardiomyopathy ☐ Hyperammonemia ☐ Seizures
☐ Coarse features ☐ Hypoglycemia ☐ Skeletal anomalies
☐ Corneal clouding ☐ Macrocephaly ☐ Other symptom(s): _____
☐ Developmental Delay ☐ Microcephaly

List the patient's medications, including antibiotics, anticonvulsants, and enzyme replacement therapy: _____

_____

_____

List the patient's specific diet or formula: _____

_____

_____

Are the patient's parents related to one another? ..... ☐ No ☐ Yes ☐ Unknown

If yes, describe: _____

Comments or special instructions: _____

_____

_____

Please submit this form with the sample or fax this form to ARUP Biochemical Genetics Laboratory at 801-584-5249.

For questions, contact the ARUP Biochemical Genetics Laboratory at 800-242-2787, ext. 3922.

Master Label