

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

**COBALAMIN/PROPIONATE/HOMOCYSTEINE-RELATED
DISORDERS GENE PANEL 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 White Other: _____

List country of origin (if known): _____

Clinical Diagnosis/Reason for Referral:

Methylmalonic aciduria Homocystinuria Propionic acidemia Other _____

Patient's Symptoms (check all that apply and describe):

<input type="checkbox"/> Failure to thrive	<input type="checkbox"/> Craniofacial _____	<input type="checkbox"/> Renal _____
<input type="checkbox"/> Neurological _____	<input type="checkbox"/> Gastrointestinal _____	<input type="checkbox"/> Cutaneous _____
<input type="checkbox"/> Neuromuscular _____	<input type="checkbox"/> Hematologic _____	<input type="checkbox"/> Respiratory _____
<input type="checkbox"/> Skeletal _____	<input type="checkbox"/> Immunologic _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cardiovascular _____	<input type="checkbox"/> Ocular _____	

Laboratory Findings

*Vitamin B12 Normal (result: _____) Abnormal (result: _____) Not performed Unknown

*Methylmalonic acid before vitamin B12 therapy ... Normal Abnormal (result: _____) Not performed Unknown

*Methylmalonic acid after vitamin B12 therapy Normal Abnormal (result: _____) Not performed Unknown

***If the patient is a breastfed baby, was MATERNAL vitamin B12 deficiency excluded?** No Yes Unknown

Homocysteine, Total Normal Abnormal (result: _____) Not performed Unknown

Plasma Acylcarnitine Profile Normal Abnormal (result: _____) Not performed Unknown

Plasma Amino Acids Normal Abnormal (result: _____) Not performed Unknown

Urine Organic Acids Normal Abnormal (result: _____) Not performed Unknown

Acidosis

Hypoglycemia

Has the patient undergone previous DNA testing? No Yes Unknown

If yes, describe the gene/disorder, methodology, and results: _____

Is there any relevant family history of a cobalamin/propionate/homocysteine metabolism related disorder?

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

Master Label

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