ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

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 fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY PEDIATRIC/ADULT CYTOGENETIC (CHROMOSOME) TESTING

Patient Name _____ Date of Birth _____ Sex ☐ F ☐ M

Physician _____ Physician Phone _____

Practice Specialty _____ Physician Fax _____

Genetic Counselor _____ Counselor Phone _____

Sample Type: ☐ Peripheral blood ☐ Cord blood ☐ Buccal ☐ Skin Biopsy

Study Type

☐ Chromosome analysis (karyotype)
☐ Genomic microarray (aCGH)
☐ Chromosome analysis with reflex to microarray
☐ Genomic microarray with 5-cell chromosome study
☐ Newborn FISH panel (13, 18, 21, X, Y)
☐ FISH for specific condition (specify): _____

Indication for Testing (check all that apply—*required*)

☐ Suspected diagnosis of: ☐ Down syndrome ☐ Trisomy 18 ☐ Trisomy 13 ☐ Turner syndrome

☐ Abnormal cfDNA/NIPT in utero: ☐ T21 ☐ T18 ☐ T13 ☐ Turner syndrome ☐ XXX ☐ XXY ☐ XYY

☐ Other (specify): _____

☐ Cardiac defect (specify): _____

☐ Multiple congenital anomalies (specify): _____

☐ Intellectual and/or developmental disability

☐ Autism/Autism spectrum disorder/Pervasive developmental delay (PDD)

☐ Learning disabilities

☐ Genital anomalies

☐ Ambiguous genitalia

☐ Dysmorphic features (specify): _____

☐ Infertility

☐ Recurrent miscarriage

☐ Partner with recurrent miscarriage (partner's name): _____

☐ Other (specify): _____

☐ Family history (complete information in box below)

☐ There is a family history of a chromosome abnormality in (relationship to patient): _____

☐ Confirm an abnormality *previously identified in this patient.*

IF EITHER OF THE ABOVE IS TRUE, to ensure correct testing, please provide:

1. The name/DOB of the previously tested family member (if not patient): _____
2. The abnormality found in the patient or family member: _____
3. **A copy of the family member's/patient's previous test results.**

Please contact an ARUP genetic counselor at (800) 242-2787 ext. 2141 prior to sending a sample to help ensure that the correct test is ordered.

Master Label