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

PATIENT HISTORY FOR MOLECULAR GENETIC TESTING

Client Number: ______________________________

Patient Name: ______________________________ **Date of Birth:** ______________ **Sex:** ☐ Female ☐ Male

Physician: ______________________________ **Physician Phone:** ______________________________

Practice Specialty: ______________________________ **Physician Fax:** ______________________________

Genetic Counselor: ______________________________ **Counselor Phone:** ______________________________

Comments or Special Instructions: ______________________________

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Reason for testing (check all that apply):

☐ Asymptomatic

☐ Carrier testing

☐ Diagnostic testing

☐ Presymptomatic

☐ Symptomatic

☐ Other (describe) ______________________________

If the patient is symptomatic, list all manifestations:______________________________

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Has anyone in the patient's family had DNA testing for this disorder?

☐ No ☐ Yes, Laboratory used: ______________________________

Laboratory result: ______________________________

(Include a copy of the laboratory report)

Please include a multi-generational pedigree with disorder symptoms noted.

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

Master Label