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 PRIMARY ANTIBODY DEFICIENCY GENETIC TESTING

Patient Name: _____ **Date of Birth:** _____

Sex Assigned at Birth: ☐Female ☐Male ☐Intersex **Gender Identity (optional):** ☐Female ☐Male ☐_____

Physician: _____ **Physician Phone:** _____

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

Genetic Counselor: _____ **Counselor's Phone:** _____

Patient's Ethnicity (check all that apply)

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

Patient's diagnosis/Reason for referral:

☐ Agammaglobulinemia ☐ Common variable immunodeficiency ☐ IgA deficiency
☐ Combined immunodeficiency ☐ Hyper IgM syndrome ☐ Other: _____

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

☐ Autoimmune conditions ☐ Failure to thrive ☐ Malignancy (specify): _____ ☐ Respiratory infections
☐ Candidiasis ☐ Gastrointestinal disease ☐ Sepsis
☐ Cryptococcosis ☐ Gingivitis ☐ Meningitis ☐ Skin infections
☐ Cytopenia ☐ Granulomatous disease ☐ Neutropenia ☐ Stomatitis
☐ Empyema ☐ Histoplasmosis ☐ Oral ulcers ☐ Other symptom(s): _____
☐ Lymphadenopathy ☐ Otitis media

Laboratory Findings:

Total white blood (cells/µl)	☐ Normal	☐ Abnormal (result: _____)	☐ Not performed	☐ Unknown
Lymphocytes (cells/µl)	☐ Normal	☐ Abnormal (result: _____)	☐ Not performed	☐ Unknown
Granulocytes (cells/µl)	☐ Normal	☐ Abnormal (result: _____)	☐ Not performed	☐ Unknown
Monocytes (cells/µl)	☐ Normal	☐ Abnormal (result: _____)	☐ Not performed	☐ Unknown
CD3 (cells/µl)	☐ Normal	☐ Abnormal (result: _____)	☐ Not performed	☐ Unknown
CD4 (cells/µl)	☐ Normal	☐ Abnormal (result: _____)	☐ Not performed	☐ Unknown
CD45RA (cells/µl)	☐ Normal	☐ Abnormal (result: _____)	☐ Not performed	☐ Unknown
CD45RO (cells/µl)	☐ Normal	☐ Abnormal (result: _____)	☐ Not performed	☐ Unknown
CD8 (cells/µl)	☐ Normal	☐ Abnormal (result: _____)	☐ Not performed	☐ Unknown
CD19 (cells/µl)	☐ Normal	☐ Abnormal (result: _____)	☐ Not performed	☐ Unknown
B (cells/µl)	☐ Normal	☐ Abnormal (result: _____)	☐ Not performed	☐ Unknown
Memory B (cells/µl)	☐ Normal	☐ Abnormal (result: _____)	☐ Not performed	☐ Unknown
NK (cells/µl)	☐ Normal	☐ Abnormal (result: _____)	☐ Not performed	☐ Unknown
IgE serum levels	☐ Normal	☐ Abnormal (result: _____)	☐ Not performed	☐ Unknown
IgG/A/M serum levels	☐ Normal	☐ Abnormal (result: _____)	☐ Not performed	☐ Unknown
Lymphocyte response to mitogens	☐ Normal	☐ Abnormal (result: _____)	☐ Not performed	☐ Unknown

Has the patient had an allogeneic bone marrow or umbilical cord blood transplant? ☐ No ☐ Yes ☐ Unknown

Is the patient on immunoglobulin replacement therapy? ☐ No ☐ Yes ☐ Unknown

Has the patient undergone previous DNA testing for this condition? ☐ No ☐ Yes ☐ Unknown

If yes, describe the gene(s), methodology, and results: _____

Is there any relevant family history? ☐ No ☐ Yes ☐ Unknown

If yes, attach a pedigree or specify each relative's relationship to the patient. List their symptoms/diagnosis 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).

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

Master Label