

**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 or Latino  Native American  
 Ashkenazi Jewish  White  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/ $\mu$ l) .....  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
 Lymphocytes (cells/ $\mu$ l) .....  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
 Granulocytes (cells/ $\mu$ l) .....  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
 Monocytes (cells/ $\mu$ l) .....  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
 CD3 (cells/ $\mu$ l) .....  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
 CD4 (cells/ $\mu$ l) .....  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
 CD45RA (cells/ $\mu$ l) .....  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
 CD45RO (cells/ $\mu$ l) .....  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
 CD8 (cells/ $\mu$ l) .....  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
 CD19 (cells/ $\mu$ l) .....  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
 B (cells/ $\mu$ l) .....  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
 Memory B (cells/ $\mu$ l) .....  Normal  Abnormal (result: \_\_\_\_\_)  Not performed  Unknown  
 NK (cells/ $\mu$ l) .....  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**