

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

### MODY AND NEONATAL DIABETES 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): \_\_\_\_\_

Does the patient have symptoms?  No  Yes (If yes, age of onset: \_\_\_\_\_) Check all symptoms that apply below.

- |  |  |
|--|--|
| <input type="checkbox"/> Persistent hyperglycemia (plasma glucose: _____mg/dL) | <input type="checkbox"/> Endogenous insulin production 5 years after onset |
| <input type="checkbox"/> Glucosuria  | <input type="checkbox"/> Low insulin requirement                           |
| <input type="checkbox"/> Ketonuria   | <input type="checkbox"/> Lack of obesity or acanthosis nigricans           |
| <input type="checkbox"/> Intrauterine growth restriction                       | <input type="checkbox"/> Lack of ketoacidosis when insulin omitted         |
| <input type="checkbox"/> Absence of pancreatic islet antibodies                | <input type="checkbox"/> Normal triglyceride and HDL levels                |
| <input type="checkbox"/> Low or undetectable plasma insulin and C-peptide      | <input type="checkbox"/> Measurable C-peptide                              |
| <input type="checkbox"/> Low fecal elastase and high stool fat                 |  |
| <input type="checkbox"/> Other symptom(s): _____                               |  |

Has the patient undergone previous germline DNA testing for MODY or neonatal diabetes? .....  No  Yes  Unknown

If yes, describe the test(s) and results: \_\_\_\_\_

Is there any relevant family history of MODY or neonatal diabetes? .....  No  Yes  Unknown

If yes, attach a pedigree or specify the relative's diagnosis and relationship to the patient. List symptoms and age of onset: \_\_\_\_\_

Has DNA testing been performed for family member(s)? .....  No  Yes  Unknown

If yes, attach a copy of the relative's DNA laboratory result.

Master Label

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