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 complete and submit with the test request form or electronic packing list.

PATIENT HISTORY FOR FAMILY—SPECIFIC MUTATON TESTING

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ Female ☐ Male

Ordering Provider: _____ **Provider's Phone:** _____

Practice Specialty: _____ **Provider's Fax:** _____

Genetic Counselor: _____ **Counselor Phone:** _____

Patient's Ethnicity/Ancestry (check all that apply)

☐ African American/Black ☐ Asian ☐ Hispanic ☐ White ☐ Other: _____

List country of origin (if known): _____

Disease/gene for which the patient is seeking testing: _____

Does the patient have symptoms? ..... ☐ **No** ☐ **Yes**

List all symptoms: _____

Sample type:

☐ Blood ☐ Amniotic fluid* ☐ Direct Chorionic Villi**
☐ DNA ☐ Cultured Amniocytes ☐ Cultured Chorionic Villi

***A backup culture is highly recommended for all direct amniocentesis/CVS samples.**

Do you need ARUP to start a backup culture? ..... ☐ No ☐ Yes (If yes, order ARUP test code 0040182).

Will a backup culture be maintained at another lab? ..... ☐ No ☐ Yes Lab Name: _____

****Would you like direct testing performed on uncultured chorionic villi or amniotic fluid?** ..... ☐ No ☐ Yes

(Some tests have not been validated on CVS samples; please contact a genetic counselor at 800-242-2787 ext. 2141 to discuss testing options. Also, if a result is not possible, there will be an additional charge for testing cultured cells.)

☐ **An affected relative's laboratory report will accompany this sample**. To perform familial mutation testing a copy of a relative's laboratory report documenting the gene and specific mutation(s) MUST accompany this order for HIPAA compliance.

If the relative's DNA testing was NOT performed at ARUP, submission of a positive control sample from an affected relative is highly recommended. Control samples are tested at no cost and are used to confirm the patient's test results; test results are NOT issued to controls.

☐ **No control is being submitted as the affected relative was tested at ARUP Laboratories.**

Relative's name: _____ DOB: _____ Relationship to patient: _____

☐ **A sample from the affected relative will accompany the patient's sample:** Collect 3mL of whole blood from the affected relative in a lavender top (EDTA) tube and ship refrigerated. Label specimen with relative's name and birthdate and place to separate order for Sequencing Control, ARUP test code 0051610

Relative's name: _____ DOB: _____ Relationship to patient: _____

☐ **The affected relative has been contacted and has agreed to provide a sample.** We would like ARUP to send a collection kit to the affected relative, free of charge.

Relative's name: _____ DOB: _____ Relationship to the patient: _____

Relative's address: _____

_____

Relative's phone number (Required for FedEx): _____

Master Label

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