ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

500 Chipeta Way
Salt Lake City, UT 84108-1221
phone: 801-583-2787 | toll free: 800-242-2787
fax: 801-584-5249 | aruplab.com

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

BIOTINIDASE DEFICIENCY TESTING 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): _____

Did the patient have an abnormal newborn screen? ☐ No ☐ Yes ☐ Unknown

Does the patient have reduced serum biotinodase activity? ☐ No ☐ Yes ☐ Unknown

If yes, the reduced enzymatic level is consistent with: ☐ Partial deficiency ☐ Complete deficiency ☐ Unknown

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

☐ Age of onset: _____	☐ Developmental delay	☐ Speech problems
☐ Alopecia	☐ Hearing loss	☐ Vision problems
☐ Ataxia	☐ Hyptonia	☐ Other: _____
☐ Candidiasis	☐ Seizures	_____

Is there any relevant family history of biotinidase deficiency? ☐ No ☐ Yes ☐ Unknown

If yes, attach a pedigree or specify the relationship of family member(s) to the patient: _____

The relative is: ☐ a healthy carrier ☐ affected with biotinidase deficiency

List the *BTD* mutations in the family member(s): _____

_____

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

Master Label