



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.

WHOLE GENOME REANALYSIS 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): _____

Was the ORIGINAL genome data analysis performed at ARUP? No Yes

Date of original genome sequencing analysis: _____

What current diagnoses or diagnostic categories are being considered for this patient? _____

Please describe any NEW significant clinical findings: _____

Master Label

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