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.

OSTEOGENESIS IMPERFECTA (OI) AND LOW BONE DENSITY PANEL 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): _____

Does the patient have SYMPTOMS of OI? ☐ No ☐ Yes (please check all that apply)

☐ Blue/gray sclera
☐ Bone fractures (approximate number): _____ Please list which bones have been fractured: _____
☐ Conductive/sensorineural hearing loss
☐ Dentinogenesis imperfecta
☐ Early onset arthritis/joint hypermobility
☐ Low bone mass/osteoporosis
☐ Protrusion acetabuli
☐ Short stature
☐ Skeletal deformities

Type of OI suspected: ☐ Type I ☐ Type II ☐ Type III ☐ Type IV ☐ Other: _____ ☐ Unknown

Has the patient undergone previous molecular genetic testing? ..... ☐ 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 the relative's relationship to the patient. List their symptoms 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 mutation testing.)

Master Label

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