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.

FAMILIAL MEDITERRANEAN FEVER (FMF) 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? ..... ☐ No ☐ Yes (check all that apply and describe)

☐ Abdominal pain
☐ Chest pain
☐ Colchicine treatment responsive
☐ End stage renal disease
☐ Joint pain/arthritis
☐ Peritonitis
☐ Pleuritis
☐ Recurrent fever
☐ Renal amyloidosis
☐ Skin eruption/inflammation
☐ Other symptom(s): _____

Laboratory Findings

Erythrocyte Sedimentation Rate (ESR)	☐ Normal	☐ Abnormal	☐ Not performed	☐ Unknown
Leukocytosis (WBC)	☐ Normal	☐ Abnormal	☐ Not performed	☐ Unknown
Fibrinogen Serum Concentration	☐ Normal	☐ Abnormal	☐ Not performed	☐ Unknown

Has the patient undergone previous DNA testing? ..... ☐ No ☐ Yes ☐ Unknown

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

Is there any relevant family history of FMF? ..... ☐ No ☐ Yes ☐ Unknown

If yes, describe: _____

The relative is: ..... ☐ a healthy carrier ☐ affected

If applicable, attach a copy of the relative's DNA laboratory result. (REQUIRED for familial variant testing.

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

Master Label