

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)

- | | | |
|--|---|--|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Peritonitis | <input type="checkbox"/> Other symptom(s): _____ |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Pleuritis | _____ |
| <input type="checkbox"/> Colchicine treatment responsive | <input type="checkbox"/> Recurrent fever | _____ |
| <input type="checkbox"/> End stage renal disease | <input type="checkbox"/> Renal amyloidosis | |
| <input type="checkbox"/> Joint pain/arthritis | <input type="checkbox"/> Skin eruption/inflammation | |

Laboratory Findings

Erythrocyte Sedimentation Rate (ESR)	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not performed	<input type="checkbox"/> Unknown
Leukocytosis (WBC)	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not performed	<input type="checkbox"/> Unknown
Fibrinogen Serum Concentration	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not performed	<input type="checkbox"/> 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.)

Check the test you intend to order.

- 3004434 Familial Mediterranean Fever (MEFV) Sequencing:** Sequencing of the entire *MEFV* coding region and intron/exon boundaries; clinical sensitivity is approximately 75-90%.

Master Label

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