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.

HOLOPROSENCEPHALY PANEL PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ 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/pregnancy have a diagnosis of holoprosencephaly? .....☐ No ☐ Yes (check one of the following)

☐ Alobar ☐ Semilobar ☐ Lobar ☐ Middle interhemispheric variant ☐ Microform ☐ Other: _____

Other findings:

☐ Microcephaly
☐ Single central incisor
☐ Short stature/failure to thrive
☐ Laterality defect (describe): _____
☐ Craniofacial (describe): _____
☐ Neurological (describe): _____
☐ Cardiac defect (describe): _____
☐ Urogenital anomalies (describe): _____
☐ Endocrine issues (describe): _____
☐ Gastrointestinal anomalies (describe): _____
☐ Ectro-/Polydactyly (describe): _____
☐ Other: _____

Has the patient undergone previous testing for holoprosencephaly? ☐ No ☐ Yes (check all that apply and describe results)

☐ Chromosome analysis: _____
☐ Genomic microarray: _____
☐ Other genetic test(s): _____

Is there any relevant family history of holoprosencephaly? .....☐ 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).

Check the test you intend to order.

☐ **2008848 Holoprosencephaly Panel, Sequencing and Deletion/Duplication**

☐ **2008863 Holoprosencephaly Panel, Sequencing and Deletion/Duplication, Fetal**: Order maternal cell contamination separately (test code 0050608)

☐ **2001961 Familial Mutation, Targeted Sequencing:** Tests for a sequence variant previously identified in a family member; a copy of a relative's lab result is REQUIRED

Master Label

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