ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

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 fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR HOLOPROSENCEPHALY PANEL

Patient Name _____ Date of Birth _____ Sex ☐ F ☐ M

Physician _____ Physician Phone _____

Practice Specialty _____ Physician Fax _____

Genetic Counselor _____ Counselor Phone _____

Patient's Ethnicity (check all that apply)

☐ African-American ☐ Asian ☐ Hispanic ☐ Native American

☐ Ashkenazi Jewish ☐ Caucasian ☐ Middle Eastern ☐ Other: _____

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? ☐ No ☐ Yes ☐ Unknown

If yes, attach a pedigree or specify the affected 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:** Testing for a variant previously identified in a family member; a copy of relative's lab result is REQUIRED.

Master Label

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