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.

SKELETAL DYSPLASIA 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): _____

Suspected diagnosis:

☐ Achondrogenesis
☐ Achondroplasia
☐ Campomelic dysplasia
☐ Diastrophic dysplasia
☐ Osteogenesis imperfecta (specify type):_____
☐ Thanatophoric dysplasia
☐ Unknown
☐ Other: _____

Patient is: ☐ Living ☐ Deceased
Describe circumstances: _____

Does the patient have symptoms? ..... ☐ No ☐ Yes (check all that apply)

☐ Abnormal ribs or small chest ☐ Extra fingers or toes ☐ Shortening of bones of arms and legs
☐ Bowed or fractured bones ☐ Hydrops ☐ Undermineralization of bones
☐ Clubfeet ☐ Irregular, thickened, or thin bones ☐ Other _____

Does the patient have radiographic findings? ..... ☐ No ☐ Yes; describe details below ☐ 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 If yes, ☐ Unknown
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 If ☐ Unknown
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.