ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

500 Chipeta Way
Salt Lake City, UT 84108-1221
phone: 801-583-2787 | toll free: 800-242-2787
fax: 801-584-5249 | aruplab.com

THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

FATTY ACID OXIDATION DISORDERS (FAOD) PANEL 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): _____

Did the patient have an abnormal newborn screen (NBS)? ..... ☐ No ☐ Yes ☐ Unknown
If yes, list what the NBS was abnormal for:

_____

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

☐ Cardiomyopathy	☐ Hepatomegaly	☐ Myopathy/myalgia
☐ Coma	☐ Hypoglycemia	☐ Reye-like syndrome
☐ Encephalopathy	☐ Lethargy	☐ Rhabdomyolysis
☐ Episodic emesis	☐ Liver failure	☐ Seizures

☐ Other symptoms: _____

Laboratory findings:

Plasma acylcarnitine profile:	☐ Normal	☐ Abnormal	☐ Not performed	☐ Unknown
Urine organic acids:	☐ Normal	☐ Abnormal	☐ Not performed	☐ Unknown
Plasma carnitine (without supplements): Free/total:	☐ Normal	☐ Abnormal	☐ Not performed	☐ Unknown
Other, describe.....	☐ Normal	☐ Abnormal	☐ Not performed	☐ Unknown

Has the patient had an allogeneic bone marrow or umbilical cord blood transplant? ..... ☐ No ☐ Yes ☐ Unknown

Has the patient undergone previous DNA testing for FAOD? ..... ☐ No ☐ Yes ☐ Unknown
If yes, describe the test(s) and results: _____

_____

Is there any relevant family history of FAOD? ..... ☐ 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 variant testing).

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

Master Label