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.

VERY LONG CHAIN ACYL-CoA DEHYDROGENASE (VLCAD) DEFICIENCY 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? ..... ☐ No ☐ Yes ☐ Unknown

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

☐ Cardiomyopathy	☐ Hypoglycemia	☐ Rhabdomyolysis
☐ Coma	☐ Lethargy	☐ Other symptom(s): _____
☐ Encephalopathy	☐ Liver failure	_____
☐ Hepatomegaly	☐ Reye-like syndrome	_____

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

Is there any relevant family history? ..... ☐ No ☐ Yes ☐ Unknown
If yes, attach a pedigree or specify the relative's relationship to the patient: _____

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).

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

Master Label