

500 Chipeta Way Salt Lake City, UT 84108-1221 phone: 801-583-2787 | toll free: 800-242-2787 fax: 801-584-5236 | aruplab.com

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

EXOME/GENOME REANALYSIS PATIENT HISTORY FORM

Patient Name:	Date of Birth:
Sex Assigned at Birth: □Female □Male □Intersex Ordering Provider:	Gender Identity (optional): □ Female □ Male □Provider's Phone:
	Provider's Fax:
	Counselor's Phone:
Reanalysis is being requested for: Exome sequencing	☐ Genome sequencing ☐ Rapid genome sequencing
Was the ORIGINAL exome or genome sequencing data anal	ysis performed at ARUP? 🗆 No 🗆 Yes
Date of original analysis:	
Dates of any previously performed REANALYSES:	
What current diagnoses or diagnostic categories are being	considered for this patient?
Please describe any NEW significant clinical findings:	
the patient's phenotype. In addition, candidate variants tha reported (e.g., de novo variant in a gene of uncertain signifi autosomal recessive gene, heterozygous variant in an auto phenotype, etc.)	vill report variants that are known or suspected to be causative for t are not known to be causative for the patient's phenotype may be cance, trans-heterozygous variants of uncertain significance in an somal recessive gene which has clinical overlap with the patient's
Please order the corresponding reanalysis test code:	
3001457 Exome Reanalysis	
No specimen required (please request test order be release original exome testing was ordered from ARUP Laboratorie	d immediately). Exome reanalysis can only be performed if the s after April 1, 2015.
3005939 Genome or Rapid Genome Reanalysis	
No specimen required (please request test order be release or rapid genome sequencing.	d immediately). Order for reanalysis of either genome sequencing
	Master Labei
For questions, contact an ARUP genetic counselor at 800-	Master Label