



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.

EXOME REANALYSIS PATIENT HISTORY FORM

Patient Name: _____ Date of Birth: _____ Sex: 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): _____

Was the ORIGINAL exome data analysis performed at ARUP? No Yes

Date of original exome sequencing 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: _____

Check the test you intend to order.

3001457 Exome Reanalysis (Originally tested at ARUP - No Specimen Required)



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