ARUP LABORATORIES

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

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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.

EXOME REANALYSIS 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): _____

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: _____

_____

_____

_____

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

Master Label