ARUP LABORATORIES

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

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Salt Lake City, UT 84108-1221
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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.

CELL CULTURE 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:** _____

NOTE: Cell culturing is offered in conjunction with testing at ARUP. Please contact an ARUP genetic counselor at 800-242-2787 ext. 2141 with any questions.

Reason for culturing (check all that apply):

☐ **Potential additional testing is desired but not yet finalized and/or dependent on current fetal testing results**

☐ **Store long-term backup cultures** (two T-25 flasks frozen and retained for 6 months)

☐ **Culture cells for testing performed at ARUP** (a separate order for the test is required)

FETAL (Amniotic fluid or CVS)

- ☐ **0051265** Achondroplasia (FGFR3) 2 Mutations, Fetal
- ☐ **3019566** Alpha Globin (HBA1 and HBA2) Sequencing and Deletion/Duplication, Fetal
- ☐ **3003656** Alpha Thalassemia (HBA1 and HBA2) Deletion/Duplication with reflex to Hb Constant Spring, Fetal
- ☐ **3019803** Angelman Syndrome and Prader-Willi Syndrome by Methylation-Specific MLPA, Fetal
- ☐ **3004550** Beta Globin (HBB) Sequencing, Fetal
- ☐ **2013662** Cystic Fibrosis (CFTR) Expanded Variant Panel, Fetal
- ☐ **2011231** Duchenne/Becker Muscular Dystrophy (DMD) Deletion/Duplication, Fetal
- ☐ **3005869** Familial Targeted Sequencing, Fetal
- ☐ **2009034** Fragile X (FMR1) with Reflex to Methylation Analysis, Fetal
- ☐ **0051270** Galactosemia (GALT) 9 Mutations, Fetal
- ☐ **2001755** Hemophilia A (F8) 2 Inversions, Fetal
- ☐ **2008863** Holoprosencephaly Panel, Sequencing and Deletion/Duplication, Fetal
- ☐ **3019937** Huntington Disease (HD) CAG Repeat Expansion, Fetal
- ☐ **3016676** Kell K/k (KEL) Antigen Genotyping, Fetal
- ☐ **2010769** Noonan Spectrum Disorders Panel, Sequencing, Fetal
- ☐ **3016639** Red Blood Cell Antigen Genotyping, Fetal
- ☐ **3016679** RhC/c (RHCE) Antigen Genotyping, Fetal
- ☐ **3016640** RhD Gene (RHD) Copy Number, Fetal
- ☐ **3016682** RhE/e (RHCE) Antigen Genotyping, Fetal
- ☐ **3016673** Platelet Antigen Genotyping Panel, Fetal
- ☐ **2012010** Skeletal Dysplasia Panel, Sequencing and Deletion/Duplication, Fetal
- ☐ **2013444** Spinal Muscular Atrophy (SMA) Copy Number Analysis, Fetal
- ☐ **3002096** Tuberous Sclerosis Complex Panel, Sequencing and Deletion/Duplication, Fetal
- ☐ **Other (**specify) _____

FIBROBLASTS

- ☐ **3001615** Hereditary Bone Marrow Failure Panel, Sequencing and Deletion/Duplication
- ☐ **3005721** Hereditary Erythrocytosis Panel, Sequencing
- ☐ **3001842** Hereditary Myeloid Neoplasms Panel, Sequencing

☐ **Culture cells for testing at external laboratory** (a separate order should **not** be placed with ARUP)

NOTE: *It is the responsibility of the requesting provider to make sure all requirements for external testing are met including sample type, required paperwork, signatures, control samples, etc.*

Performing facility _____

Test code and test name _____

Flasks required for additional testing ..... ☐ 2 T25 ☐ 4 T25 ☐ Other (specify)_____

If there is residual maternal DNA from previous testing at ARUP, should it be forwarded to the performing lab? ☐ No ☐ Yes ☐ N/A

Will billing and reporting be done through ARUP? ..... ☐ Yes ☐ No (TRF required)

If a frozen backup is desired at ARUP, please also select "store long-term backup cultures."

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