ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

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 fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR AUTISM AND INTELLECTUAL DISABILITY

Patient Name _____ **Date of Birth** _____ **Sex** ☐ F ☐ M

Physician _____ **Physician Phone** _____

Practice Specialty _____ **Physician Fax** _____

Genetic Counselor _____ **Counselor Phone** _____

Patient's Ethnicity (check all that apply)

☐ African-American ☐ Asian ☐ Hispanic ☐ Native American
☐ Ashkenazi Jewish ☐ Caucasian ☐ Middle Eastern ☐ Other: _____

Clinical Findings: (check all that apply)

Growth
☐ Failure to thrive
☐ Overgrowth
☐ Short stature

Development
☐ Fine motor delay
☐ Gross motor delay
☐ Speech delay

Biochemical
☐ Acidosis
☐ Hypoglycemia
☐ Hyperammonemia

Genitourinary
☐ Ambiguous genitalia
☐ Hydronephrosis
☐ Undescended testes

Cognition/behavior
☐ Autism spectrum disorder
☐ Learning disability
☐ Intellectual disability; (IQ/DQ: _____)
☐ Oppositional/defiant disorder
☐ Obsessive compulsive disorder
☐ Pervasive developmental delay

Neurologic
☐ Ataxia/dystonia/chorea
☐ Hypotonia
☐ Seizures
☐ Spasticity
☐ Structural brain abnormality

Cardiac
☐ Cardiomyopathy
☐ Structural heart defect (describe: _____)

Musculoskeletal
☐ Scoliosis
☐ Vertebral anomaly
☐ Limb anomaly
☐ Organomegaly

Craniofacial
☐ Dysmorphic facial features
☐ Cleft lip +/- cleft palate
☐ Craniosynostosis
☐ Macrocephaly
☐ Microcephaly
☐ Corneal clouding

List patient's medications and, if applicable, describe modified diet. Include formulas, vitamins, supplements, antibiotics, anticonvulsants, or enzyme replacement therapy: _____

Has the patient undergone previous DNA testing? ☐ No ☐ Yes ☐ Unknown
If yes, describe the test(s) and results: _____

Is there any relevant family history? ☐ No ☐ Yes ☐ Unknown
If yes, attach a pedigree or specify the relative's relationship to the patient. List their diagnoses and age of onset:

Has DNA testing been performed for the family member(s)? ☐ No ☐ Yes ☐ Unknown
If yes, describe the test(s) and results: _____

Are the patient's parents related to one another? ☐ No ☐ Yes (describe: _____) ☐ Unknown

In cooperation with the National Institutes of Health's effort to improve understanding of specific genetic variants, ARUP submits HIPAA-compliant, de-identified (cannot be traced back to the patient) genetic test results and health information to public databases. The confidentiality of each sample is maintained. If you prefer that your test result not be shared, call ARUP at (800) 242-2787, ext. 3301. Your de-identified information will not be disclosed to public databases after your request is received, but a separate request is required for each genetic test. Additionally, patients have the opportunity to participate in patient registries and research. To learn more, visit www.aruplab.com/genetics/resources.

Check the test you intend to order.

Primary panel for Autism/Intellectual Disability:

☐ **2014314 Autism and Intellectual Disability Comprehensive Panel**

Individual components are available separately:

☐ **2003414 Cytogenomic SNP Microarray**
☐ **2009033 Fragile X (FMR1) with Reflex to Methylation Analysis**
☐ **2014312 Autism and Intellectual Disability Metabolic Panel**

Master Label

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