ARUP LABORATORIES

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.

PATIENT HISTORY FOR CYSTIC FIBROSIS (CF), FRAGILE X SYNDROME (FXS), AND SPINAL MUSCULAR ATROPHY (SMA) CARRIER SCREENING

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): _____

Reason for Referral:

☐ Carrier screen: Patient has no symptoms or family history of cystic fibrosis (CF), fragile X syndrome (FXS), or spinal muscular atrophy (SMA).

☐ Family history is positive for ☐ CF ☐ FXS ☐ SMA
Relationship of affected relative to patient: _____
The relative is: ☐ a healthy carrier ☐ affected
Has DNA testing been performed for the family member(s)? ☐ No ☐ Yes ☐ Unknown
If yes, attach a copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing)
or describe the test results: _____

☐ Known carrier: Patient is a known healthy carrier of (has had previous testing): ☐ CF ☐ FXS ☐ SMA
Test result of patient: _____

☐ Other: (e.g., abnormal ultrasound finding) Please describe: _____

Is reproductive partner symptomatic or a known healthy carrier ? ☐ No ☐ Yes, (specify: ☐ CF ☐ FXS ☐ SMA) ☐ NA
Partner is: ☐ a healthy carrier ☐ affected/symptomatic
Has DNA testing been performed for the partner? ☐ No ☐ Yes ☐ Unknown
If yes, describe the test result: _____

Does reproductive partner have a family history of CF, FXS, or SMA? ☐ No ☐ Yes, (specify: ☐ CF ☐ FXS ☐ SMA) ☐ NA
Relationship of affected relative to partner: _____
Relative is: ☐ a healthy carrier ☐ affected/symptomatic
Has DNA testing been performed for the relative? ☐ No ☐ Yes ☐ Unknown
If yes, describe the test results: _____

Master Label

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