

THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

FAMILY MEMBER CONTROL HISTORY FOR EXOME SEQUENCING

Control's Name: _____ **Date of Birth:** _____ **Sex:** Female Male

Relationship of control to the patient: _____

Patient's Name: _____ **Patient's Date of Birth:** _____

Patient's Ethnicity (check all that apply)

African American/Black Asian Hispanic White Other: _____

List country of origin (if known): _____

Does this control have ANY medical conditions or learning disabilities? No Yes Unknown

Is this control thought to be affected with the same condition as the proband? No Yes Unknown

Describe ALL past and present clinical findings in the control and age of occurrence:

- Cardiac: _____
- Craniofacial: _____
- Dermatologic: _____
- Dysmorphic Features: _____
- Genital: _____
- Growth: _____
- Hematologic: _____
- Immunologic: _____
- Metabolic: _____
- Neurologic: _____
- Optical: _____
- Otologic: _____
- Skeletal: _____
- Urinary tract: _____
- Other: _____

Describe any major acute or chronic illnesses, hospitalizations, or surgeries: _____

Has the control individual undergone previous genetic testing No Yes Unknown

If yes, describe the test(s) and results: _____

Check the test you intend to order.

- 2006340 Exome Sequencing, Familial Control, Tracking:** Order for parents and family members of patient having EXOME SEQUENCING, TRIO (2006332). Samples undergo full exome sequencing to aid interpretation of patient's result. Independent report of ACMG variants issued if separate consent is provided for each family member.
- 3001114 Exome Control, Targeted Sequencing:** Order for parents and family members of patient having EXOME SEQUENCING, PROBAND (20036336). Samples undergo targeted sequencing to aid patient's result interpretation. ACMG variants not issued to controls.

Master Label

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