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.

FAMILY MEMBER CONTROL HISTORY FOR EXOME SEQUENCING

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

Sex Assigned at Birth: ☐Female ☐Male ☐Intersex **Gender Identity (optional):** ☐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: _____

Master Label

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