ARUP® LABORATORIES

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform molecular genetic testing.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR MOLECULAR GENETIC TESTING

Client Number ____________________

Patient's Name ____________________________ **Date of Birth**_____ /_____/_____ **Gender [ ] F [ ] M**

Physician ____ **Physician Phone** (_____)________________

Genetic Counselor _______________________________ **Counselor Phone** (_____)________________

Comments or Special Instructions____

____

REASON FOR TESTING (check all that apply)

[ ] Asymptomatic [ ] Presymptomatic [ ] Symptomatic
[ ] Diagnostic testing [ ] Carrier testing [ ] Other (describe) ________________________

IF PATIENT IS SYMPTOMATIC, PLEASE LIST ALL MANIFESTATIONS.

____

____

HAS ANYONE IN THE PATIENT'S FAMILY HAD DNA TESTING FOR THIS DISORDER?

[ ] YES [ ] NO

If yes, list laboratory used ____

Laboratory result ____
(Please include copy of laboratory report.)

PLEASE DRAW A MULTI-GENERATIONAL PEDIGREE BELOW WITH DISORDER SYMPTOMS NOTED, OR ATTACH A PEDIGREE.

Master Label