ARUP LABORATORIES

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform biochemical genetic testing.
For electronic orders only, please fill out and submit with the electronic packing list.

PATIENT HISTORY FOR BIOCHEMICAL GENETIC TESTING

Client Number _____

Patient Name _____ Date of Birth _____ Gender [ ] Female [ ] Male

Physician _____ Physician Phone (_____)_____

Genetic Counselor_____ Counselor Phone (_____)_____

Comments or Special Instructions _____

_____

Referring Diagnosis _____

_____

PATIENT SYMPTOMS

[ ] Acidosis	[ ] Hypoglycemia	[ ] Hyperammonemia	[ ] Failure to thrive
[ ] Seizures	[ ] Macrocephaly	[ ] Microcephaly	[ ] Developmental delay
[ ] Coarse features	[ ] Organomegaly	[ ] Skeletal anomalies	[ ] Corneal clouding
[ ] Cardiomyopathy		[ ] Other _____	

PATIENT ETHNICITY (check all that apply)

[ ] African American	[ ] Ashkenazi Jewish	[ ] Asian	[ ] Caucasian
[ ] Hispanic	[ ] Middle Eastern	[ ] Native American	[ ] Other_____

LIST THE PATIENT'S MEDICATIONS, INCLUDING ANTIBIOTICS, ANTICONVULSANTS, AND ENZYME REPLACEMENT THERAPY.

_____

LIST THE PATIENT'S SPECIFIC DIET OR FORMULA.

_____

ARE THE PATIENT'S PARENTS RELATED TO ONE ANOTHER?

[ ] No [ ] Yes [ ] Unknown If yes, please describe_____

Please submit with sample or fax this form to ARUP Biochemical Genetics Laboratory at (801) 584-5249.

Master Label