

**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/Genetic Counselor \_\_\_\_\_ Phone # \_\_\_\_\_

Comments or Special Instructions \_\_\_\_\_

Referring Diagnosis \_\_\_\_\_

**PATIENT SYMPTOMS**

- |  |                                       |   |  |
|--|---------------------------------------|---|--|
| <input type="checkbox"/> Acidosis        | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Hyperammonemia     | <input type="checkbox"/> Failure to thrive   |
| <input type="checkbox"/> Seizures        | <input type="checkbox"/> Macrocephaly | <input type="checkbox"/> Microcephaly       | <input type="checkbox"/> Developmental delay |
| <input type="checkbox"/> Coarse features | <input type="checkbox"/> Organomegaly | <input type="checkbox"/> Skeletal anomalies | <input type="checkbox"/> Corneal clouding    |
| <input type="checkbox"/> Cardiomyopathy  |                                       | <input type="checkbox"/> Other _____        |  |

**PATIENT ETHNICITY (check all that apply)**

- |   |   |  |                                      |
|---|---|--|--------------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Asian           | <input type="checkbox"/> Caucasian   |
| <input type="checkbox"/> Hispanic         | <input type="checkbox"/> Middle Eastern   | <input type="checkbox"/> Native American | <input type="checkbox"/> 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