ARUP LABORATORIES

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

PATIENT HISTORY FOR FAMILY SPECIFIC MUTATION TESTING

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

Physician ______________________________ **Physician Phone** (_____)_____________**Practice Specialty**____________

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

Disease/Gene for which the patient is seeking testing: ____
Does the patient have SYMPTOMS?
[ ] **No** [ ] **Yes, please list all symptoms**____

Sample Type

[ ] Blood	[ ] Amniotic Fluid*	[ ] Direct Chorionic Villi**
[ ] DNA	[ ] Cultured Amniocytes	[ ] Cultured Chorionic Villi

* A backup culture is highly recommended for all direct amniocentesis/CVS samples.
Do you need ARUP to start a backup culture? [ ] No [ ] Yes (If yes, order ARUP test code 0040182)
Will a backup culture be maintained at another lab? [ ] No [ ] Yes Lab Name______________________

** Would you like direct testing performed on uncultured chorionic villi or amniotic fluid? [ ] Yes [ ] No
(Since some tests have not been validated on CVS samples, please contact a genetic counselor (800) 242-2787 x2141 to discuss testing options. Additionally, if a result is not possible, there will be an additional charge for testing cultured cells.)

To perform familial mutation testing, a copy of a relative's laboratory report documenting the gene and specific mutation(s) MUST accompany this order for HIPAA compliance.

[ ] An affected relative's laboratory report will accompany this sample.

If the relative's DNA testing was NOT performed at ARUP, submission of a control sample from an affected relative is highly recommended. Control samples are tested at no cost and are used to confirm the patient's test results; test results are NOT issued to controls.

[ ] **No control is being submitted** as the affected relative was tested at ARUP labs.
Relative's name: ____
Relative's relationship to the patient?____

[ ] **A control sample from the affected relative will accompany the patient's sample**. (Collect 3mL of whole blood in a lavender top (EDTA) tube and ship refrigerated. Order SEQCONTROL, ARUP test code 0051610. Note the name and birth date of the person providing the control sample on the patient's test requisition.)

[ ] **The affected relative is not presently available**. We would like ARUP to contact the patient or the patient's guardian to arrange to have a saliva kit sent to the affected relative.
Patient/ Guardian's name______________________________ Phone number____________________________

[ ] **Please run this patient's test WITHOUT a positive control sample**.

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

Master Label