ARUP® LABORATORIES

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

[ ] Acidosis [ ] Hypoglycemia [ ] Hyperammonemia [ ] Failure to thrive
[ ] Seizures [ ] Macrocephaly [ ] Microcephaly [ ] Developmental delay

PATIENT ETHNICITY

____

LIST THE PATIENT'S MEDICATIONS, INCLUDING ANTICONVULSANTS.

____

LIST THE PATIENT'S SPECIFIC DIET OR FORMULA.

____

ARE THE PATIENT'S PARENTS RELATED TO ONE ANOTHER?

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

Master Label

Please submit with sample or fax this form directly to Dr. Marzia Pasquali, Biochemical Genetics Laboratory, (801) 584-5207.