

THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

GENOMIC MICROARRAY TESTING PATIENT HISTORY FORM

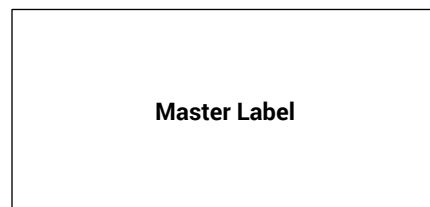
Patient Name: _____ **Date of Birth:** _____
Sex Assigned at Birth: Female Male Intersex **Gender Identity (optional):** Female Male _____
Ordering Provider: _____ **Provider's Phone:** _____
Practice Specialty: _____ **Provider's Fax:** _____
Genetic Counselor: _____ **Counselor's Phone:** _____

Clinical Information (check all that apply)

- | | | | |
|--|--|--|---|
| Perinatal History
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Within normal limits
<input type="checkbox"/> Prematurity
<input type="checkbox"/> IUGR
<input type="checkbox"/> Oligohydramnios
<input type="checkbox"/> Polyhydramnios
<input type="checkbox"/> Other: _____ | Behavioral
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Within normal limits
<input type="checkbox"/> Asperger syndrome features
<input type="checkbox"/> Autism
<input type="checkbox"/> Oppositional defiant disorder
<input type="checkbox"/> Obsessive compulsive disorder
<input type="checkbox"/> Pervasive developmental delay
<input type="checkbox"/> Other: _____ | Craniofacial
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Within normal limits
<input type="checkbox"/> Cleft lip +/- cleft palate
<input type="checkbox"/> Cleft palate alone
<input type="checkbox"/> Coloboma
<input type="checkbox"/> Craniosynostosis
<input type="checkbox"/> Dysmorphic facial features
<input type="checkbox"/> Ear malformation
<input type="checkbox"/> Macrocephaly
<input type="checkbox"/> Microcephaly
<input type="checkbox"/> List HC, if known: _____
<input type="checkbox"/> Other: _____ | Gastrointestinal
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Within normal limits
<input type="checkbox"/> Gastroschisis
<input type="checkbox"/> Hirschsprung disease
<input type="checkbox"/> Omphalocele
<input type="checkbox"/> Pyloric stenosis
<input type="checkbox"/> Tracheoesophageal fistula
<input type="checkbox"/> Other: _____ |
| Growth
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Within normal limits
<input type="checkbox"/> Failure to thrive
<input type="checkbox"/> Overgrowth
<input type="checkbox"/> Short stature
<input type="checkbox"/> Other: _____ | Neurological
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Within normal limits
<input type="checkbox"/> Ataxia/dystonia/chorea
<input type="checkbox"/> Hypotonia
<input type="checkbox"/> Neural tube defect
<input type="checkbox"/> Seizures
<input type="checkbox"/> Spasticity
<input type="checkbox"/> Structural brain anomaly
<input type="checkbox"/> Other: _____ | Cutaneous
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Within normal limits
<input type="checkbox"/> Hyperpigmentation
<input type="checkbox"/> Hypopigmentation | Genitourinary
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Within normal limits
<input type="checkbox"/> Ambiguous genitalia
<input type="checkbox"/> Hydronephrosis
<input type="checkbox"/> Hypospadias
<input type="checkbox"/> Kidney malformation
<input type="checkbox"/> Undescended testis
<input type="checkbox"/> Urethra/ureter obstruction
<input type="checkbox"/> Other: _____ |
| Development
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Within normal limits
<input type="checkbox"/> Fine motor delay
<input type="checkbox"/> Gross motor delay
<input type="checkbox"/> Speech delay
<input type="checkbox"/> Other: _____ | Cardiac
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Within normal limits
<input type="checkbox"/> ASD
<input type="checkbox"/> AV canal defect
<input type="checkbox"/> Coarctation of aorta
<input type="checkbox"/> Hypoplastic left heart
<input type="checkbox"/> Tetralogy of Fallot
<input type="checkbox"/> VSD
<input type="checkbox"/> Other: _____ | Musculoskeletal
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Within normal limits
<input type="checkbox"/> Contractures
<input type="checkbox"/> Club foot
<input type="checkbox"/> Diaphragmatic hernia
<input type="checkbox"/> Limb anomaly
<input type="checkbox"/> Polydactyly
<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Syndactyly
<input type="checkbox"/> Vertebral anomaly
<input type="checkbox"/> Other: _____ | Family History
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> No relevant family history
<input type="checkbox"/> Parents with
≥ two miscarriages
<input type="checkbox"/> Other relatives with
similar clinical history
(explain below) |

Clinical Descriptions—Include any additional relevant clinical information not provided above.

In cooperation with the National Institutes of Health's effort to improve understanding of specific genetic variants, ARUP submits HIPAA-compliant, de-identified (cannot be traced back to the patient) genetic test results and health information to public databases. The confidentiality of each sample is maintained. If you prefer that your test result not be shared, call ARUP at 800-242-2787 ext. 3301. Your de-identified information will not be disclosed to public databases after your request is received, but a separate request is required for each genetic test. Additionally, patients have the opportunity to participate in patient registries and research. To learn more, visit aruplab.com/genetics.



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