ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

500 Chipeta Way
Salt Lake City, UT 84108-1221
phone: 801-583-2787 | toll free: 800-242-2787
fax: 801-584-5249 | aruplab.com

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

MUCOPOLYSACCHARIDOSIS (MPS) 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:** _____

Reason for testing:

☐ Diagnostic: _____ ☐ Monitoring for: _____
☐ Abnormal newborn screen for: _____ ☐ Other: _____

Previous testing:
Enzyme testing results: _____ ☐ N/A
Genetic testing results: _____ ☐ N/A

Symptoms (please attach clinical notes if available): .....☐ No ☐ Yes (check all that apply and describe)
☐ Cardiomyopathy ☐ Coarse features ☐ Corneal clouding ☐ Developmental delay
☐ Organomegaly ☐ Short stature ☐ Skeletal anomalies ☐ Macrocephaly
☐ Other symptom(s): _____

Is the patient currently on enzyme replacement therapy? ☐ No ☐ Yes: _____

Other medications/treatments: _____

Has the patient received stem cell transplantation? ☐ No ☐ Yes **If yes, date of transplant:** _____

Family History: (Please attach pedigree)
Other similarly affected family members? _____

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

Master Label