

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 _____