

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

PATIENT HISTORY FOR FAMILIAL MEDITERRANEAN FEVER (FMF) TESTING

Patient's Name _____ Date of Birth ____/____/____ Gender F M

Physician _____ Physician Phone (____) _____ Practice Specialty _____

Genetic Counselor _____ Counselor Phone (____) _____

Patient's Ethnicity (check all that apply)
 African-American Ashkenazi Jewish Asian Caucasian
 Hispanic Middle Eastern Native American Other _____

Does the patient have SYMPTOMS? No Yes (check all that apply)
 Recurrent fever Renal amyloidosis
 Abdominal pain End stage renal disease
 Peritonitis Joint pain/arthritis
 Chest pain Skin eruption/inflammation
 Pleuritis Colchicine treatment responsive
 Other _____

LABORATORY FINDINGS

Erythrocyte sedimentation rate (ESR) Normal Abnormal Not performed Unknown
Leukocytosis (WBC) Normal Abnormal Not performed Unknown
Fibrinogen serum concentration Normal Abnormal Not performed Unknown

Does the patient have a FAMILY HISTORY of FMF? No Yes Unknown
If yes, what is the RELATIONSHIP of family member(s) to the patient? _____
Is the relative? a healthy carrier affected

Has DNA testing for FMF been performed for these family member(s)? No Yes Unknown
If yes, please describe test(s) and results _____

Has the patient undergone previous DNA testing for FMF? No Yes Unknown
If yes, please describe test(s) and results _____

Circle the FMF test you intend to order

2002658 Familial Mediterranean Fever (MEFV) Sequencing - Sequencing of the entire *MEFV* coding region and intron/exon boundaries; clinical sensitivity is approximately 80%.

2001961 Familial Mutation, Targeted Sequencing – Tests for a previously identified familial mutation. A copy of a relative's DNA laboratory result is REQUIRED.

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

Master Label