

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

PATIENT HISTORY FOR X-CHROMOSOME MICROARRAY 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)

- | | | | |
|---|---|--|--------------------------------------|
| <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 _____ |

Is the patient SYMPTOMATIC? No Yes **Suspected diagnosis** _____

Please check all symptoms that apply:

Developmental:

- | | |
|--|--|
| <input type="checkbox"/> MR <input type="checkbox"/> syndromic or <input type="checkbox"/> non-syndromic | <input type="checkbox"/> Autism/PDD |
| <input type="checkbox"/> Speech delay/loss | <input type="checkbox"/> Behavioral aberrations <input type="checkbox"/> Other _____ |

- Neurological _____
- Dysmorphic features _____
- Skeletal _____
- Craniofacial _____
- Cardiac _____
- Urinary tract _____
- Genital _____
- Optical _____
- Growth _____
- Immune _____
- Skin _____
- Metabolic _____
- Hematologic _____
- Hearing _____
- Other _____

Does the patient have a FAMILY HISTORY of a specific X-Linked disorder? No Yes Unknown

RELATIONSHIP of the affected family member(s) to the patient _____
 NAME OF THE DISORDER diagnosed in each symptomatic/affected relative _____

Is there a family history that is consistent with an X-linked disorder? No Yes Unknown

If yes, please describe _____

Please attach PEDIGREE if possible.

Is the patient suspicious for any specific X-linked disorder? No Yes

If yes, what disorder(s) _____

Has the patient undergone previous genetic testing for any X-linked disorder? No Yes

If yes, please describe _____

***If a mutation was found, please attach a copy of the lab report.**

2004434 X Chromosome Ultra-High Density Microarray, 954 Genes

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

Master Label