

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

PATIENT HISTORY FOR MOLECULAR GENETIC TESTING

Client Number _____

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

Physician _____ **Physician Phone** (____) _____

Genetic Counselor _____ **Counselor Phone** (____) _____

Comments or Special Instructions _____

REASON FOR TESTING (check all that apply)

- Asymptomatic Presymptomatic Symptomatic
 Diagnostic testing Carrier testing Other (describe) _____

IF PATIENT IS SYMPTOMATIC, PLEASE LIST ALL MANIFESTATIONS.

HAS ANYONE IN THE PATIENT'S FAMILY HAD DNA TESTING FOR THIS DISORDER?

YES NO

If yes, list laboratory used _____

Laboratory result _____
(Please include copy of laboratory report.)

PLEASE DRAW A MULTI-GENERATIONAL PEDIGREE BELOW WITH DISORDER SYMPTOMS NOTED, OR ATTACH A PEDIGREE.

Master Label