ARUP LABORATORIES

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

FAMILY MEMBER CONTROL HISTORY FOR EXOME SEQUENCING

Control's Name ____ Date of Birth______ /______/______Gender [ ] F [ ] M

Exact relationship of control to the patient____

Patient's Name ____ Patient's Date of Birth______ /______/______

Control's Ethnicity (check all that apply)
[ ] African American [ ] Ashkenazi Jewish [ ] Asian [ ] Caucasion
[ ] Hispanic [ ] Middle Eastern [ ] Native American [ ] Other___________________

Describe the control individual's current physical and mental health.
[ ] Asymptomatic [ ] Symptomatic (describe____)

Describe ALL past and present clinical findings in the control and list the age of occurrence:
[ ] Neurologic ____
[ ] Dysmorphic features ____
[ ] Growth ____
[ ] Skeletal ____
[ ] Craniofacial ____
[ ] Cardiac ____
[ ] Urinary tract ____
[ ] Genital ____
[ ] Optical ____
[ ] Otologic ____
[ ] Immunologic ____
[ ] Dermatologic____
[ ] Metabolic ____
[ ] Hematologic ____
[ ] Other ____

Describe any major acute or chronic illnesses, hospitalizations or surgeries.
____

Has the control individual undergone previous GENETIC TESTING? [ ] No [ ] Yes [ ] Unknown
If yes, please describe test(s) performed and the result(s)
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Please order the following test for each family member submitted as a control.

2006340 Exome Sequencing, Familial Control, Tracking
Order for parents or family members of the affected patient having exome sequencing. Samples will be used for interpretation of the patient's result. Independent results will not be issued for family members tested as controls.

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

Master Label