Cleveland Clinic
Laboratories

2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

PATIENT HISTORY FOR BIOCHEMICAL GENETIC TESTING

PATIENT INFORMATION

Clinic Number: _____

Patient's Last Name: _____ First Name: _____ MI: _____

Birth Date: _____ Gender: ☐ Male ☐ Female

Referring Physician (last, first): _____

Referring Physician Phone: (_____) _____ Referring Physician Fax*: (_____) _____

Genetics Counselor (last, first): _____

Genetics Counselor Phone: (_____) _____ Genetics Counselor Fax*: (_____) _____

**Fax number given must be from a fax machine that complies with applicable HIPAA regulations.*

COMMENTS OR SPECIAL INSTRUCTIONS

_____

_____

REFERRING DIAGNOSIS

_____

_____

PATIENT'S ETHNICITY (check all that apply)

☐ African American ☐ Asian ☐ Hispanic ☐ Native American
☐ Ashkenazi Jewish ☐ Caucasian ☐ Middle Eastern ☐ Other _____

PATIENT'S SYMPTOMS (check all that apply)

☐ Acidosis ☐ Failure to thrive ☐ Organomegaly
☐ Cardiomyopathy ☐ Hyperammonemia ☐ Seizures
☐ Coarse features ☐ Hypoglycemia ☐ Skeletal anomalies
☐ Corneal clouding ☐ Macrocephaly ☐ Other _____
☐ Developmental delay ☐ Microcephaly

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: _____