Clinical Questionnaire for Reveal℠ SNP Microarray - Pediatric

This form should be completed when Reveal℠ SNP Microarray - Pediatric testing is ordered. The form should be completed by the ordering physician's office and should accompany the sample. Please call 800-345-GENE (4363) and ask to speak to a cytogenetics genetic counselor with any questions.

Patient's name: **Date of birth:**

Gender ○ Male ○ Female Name of person completing form:

Physician's signature: Physician's telephone:

Primary Diagnosis

Development (any delays):

Cognitive: ○ Suspect autism spectrum disorder?

Motor (gross): (fine motor):

Growth (delays/overgrowth, etc):

Other:

Any dysmorphic features (unusual facial characteristics):

Review of systems (please comment on any issues/problems/abnormal studies associated with each system):

Neurological/Mental:

Chest/Lungs:

Heart:

Genital/Urinary:

Skeletal/Limbs:

Eyes/Skin:

Other:

Any significant prenatal history:

Abnormal labs:

Chromosome analysis results: Year performed?:

Any significant family history:

Siblings:

Mother: Maternal relatives:

Father: Paternal relatives:

Are the parents related (other than by marriage, for example first or second cousins), if so how:

Additional copies of this form can be printed from our website: www.integratedgenetics.com

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